THE UNIVERSITY OF CHICAGO ORGANIZED HEALTH CARE ARRANGEMENT
REQUEST AND AUTHORIZATION TO COPY HEALTH INFORMATION

PHONE: 773-702-1637 FAX: 773-702-7591

For the purposes of release of health information, records are available at the UC Organized Health Care Arrangement (or UC OHCA) which consists of the University of Chicago Medical Center (UCMC), certain activities of the University of Chicago including physicians, and the UCMC Regional Doctors Offices. Each of these is called a UC Organization.

Section I: PATIENT INFORMATION

Patient Name (last, first, middle initial):			
Birthdate:	Social Security Number:	Medical Record Number:	
Address			
City:	State:	Zip:	**Phone:**

Section II: INFORMATION REQUESTED

I authorize the UC Organization to use or disclose the following health information during the term of this Authorization: Check all that apply

☐ Clinic visit notes	☐ Complete Medical Record
☐ Emergency Room Report	☐ Billing records
☐ Surgical (operative report, path report)	☐ Therapy Notes (Specify: PT, Speech, Radiation, Chemo, etc.)
☐ Hospitalization (H& P, Consult, Tests, Surgical, Disch Summary)	☐ Records related to a specific injury with the following date (e.g. workers' compensation injury): _____
☐ X-ray Films (Please contact Radiology at 773-702-1788)	☒ Other : SEE ATTACHED FOR RECORDS WANTED.
☐ Test results (Specify: Lab, X-ray, EKG, etc.)	

For the following dates of treatment: (for example: specific date 1/25/03; range of dates Jan-July 2001; all dates of service)

From the following facilities:

☒ The University of Chicago Medical Center (includes The Center for Advanced Medicine)

☐ The following UCMC Regional Doctors Office: _____

☐ The University of Chicago Physicians Group

☐ The following University of Chicago Physicians: _____ _____

Section III: RECIPIENT AND PURPOSE:

If this information is not being delivered to me, then deliver my health information to: (for example: insurance company, school, attorney)

Name of Person:	Phone Number: **P: 248-357-3330 F: 248-357-3337**
Name of Organization: **RECORDS DEPOSITION SERVICE, INC.**	
Street Address: **PO BOX 5054**	
City, State, Zip: **SOUTHFIELD, MI 48086-5054**	
The purpose of the disclosure is: (for example: worker's compensation claim review; school requires immunization records; at the request of the patient) **FOR DISCOVERY BEFORE TRIAL**	

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PLEASE READ THIS PAGE CAREFULLY

Section IV: SPECIFIC CONSENT

By checking any of the boxes below, I am specifically authorizing the UC Organization(s) to use and/or disclose the category of confidential information indicated next to the box, if applicable to this authorization.

- ☐ Information about a Mental Illness or Developmental Disability**
- ☐ Psychotherapy Notes (which are not part of the official medical record)
- ☐ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about Communicable Diseases
- ☐ Information about Venereal Disease(s)
- ☐ Information about Substance (i.e., alcohol or drug) Abuse
- ☐ Information about Abuse of an Adult with a Disability
- ☐ Information about Sexual Assault
- ☐ Information about Child Abuse and Neglect
- ☐ Information about Genetic Testing

Section V: EFFECTIVE DATE OF AUTHORIZATION

This authorization will remain in effect under the following conditions: (check one preference)

- ☐ From the date of this Authorization until the following date: _____, 200_____.
- ☐ Until the purpose is fulfilled.
- ☐ Until the following event occurs: _____.
- ☐ Other (e.g. no expiration): _____.

Note: The term for mental health records must be stated—you may not use "no expiration."
If no termination event is filled in, then this Authorization will expire 90 days after the date signed below.

I understand that I may change my mind and revoke this Authorization in writing at any time by notifying the HIPAA Program Office. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that any UC Organization has already taken action where it relied on my permission. Send revocations to: HIPAA Program Office, University of Chicago, MC1000, 5841 S. Maryland Ave., Chicago, IL 60637. I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that once my health information is disclosed to the recipient, no UC Organization can guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.

I understand that I may refuse to sign this Authorization, and if I do refuse, my ability to obtain treatment will not be effected unless (a) the only purpose of treatment is to create health information for the disclosure listed above, or (b) if my treatment is related to my participation in a research study.

I have read and understand this Authorization and had a chance to ask questions about the disclosure of the health information. I authorize each UC Organization to use/disclose my health information in the manner described above.

_____ _____

Signature of Patient or Personal Representative* Date

_____ _____

Name of Personal Representative* (if applicable) Relationship to Patient

*The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.

**A witness signature is required for the release of information about a mental illness or developmental disability.

Signature of Witness: _____ Date _____

Name of Witness: _____

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