



ELMHURST CLINIC
Working together for the health of you & your family.

RELEASE OF INFORMATION

To assure that your request is completed in a timely manner, we ask that you provide us with the following items:

1. **A written authorization.** The law requires a written authorization signed by the patient or legal representative stating that the Elmhurst Clinic is allowed to release medical records and/or protected health information (PHI) to yourself or another party. If the patient is under 18 years of age, a parent or legal representative must sign the authorization.
2. **Pre-Payment.** Please refer to the fee schedule below. We accept prepayment via cash, check, or charge. In situations where pre-payment was not received, the Elmhurst Clinic will send you a bill.
 - Payment via charge cards. Please fill out the attached form with the credit card information.
 - Cash payments. Please do not send cash via mail. Please visit the Release of Information (ROI) department to make the cash payment in person. The address is listed below.
 - Check payments. Please make the check payable to the Elmhurst Clinic.

Frequently Asked Questions (FAQs)

Q: Why do I need to fill out an authorization?

A: Federal and state laws require the Elmhurst Clinic to obtain a written authorization prior to releasing any medical records or protected health information (PHI).

Q: How long does it take to complete my request?

A: Copying and sending copies of medical records could take up to 30 days to complete. Completing medical forms can take up to 10 business days.

Q: Do you fax medical records?

A: We do not fax medical records directly to patients. We will fax medical records to a physician's office if we can verify that you have an upcoming appointment. We will also fax completed medical forms to human resources at your place of employment or insurance companies in emergency situations only.

Q: Why do I have to pay the fee?

A: State laws allow us to charge a patient or requester a fee that we feel is appropriate. Our fee schedule is comparable to other facilities in the area.

Q: Can I send someone else to pick up my medical records or completed medical forms?

A: We prefer that you pick them up yourself because we need to see a picture ID. If you must send someone else, even your spouse or child, they must have a written note signed by you explaining the situation. They must also present their picture ID to identify who they are.

Fee Schedule

Patient Fee Schedule for Copies of Medical Records

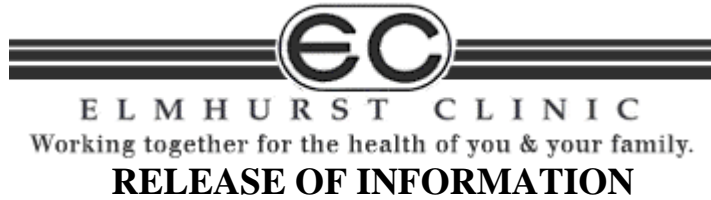
- \$.50 per page for pages 1-50 *Charges less than \$3 (5 pages) will be waived.
- \$.25 per page for pages in excess of 50 *Maximum charge not to exceed \$50

Patient Fee Schedule for Form Completion (Disability, FMLA, APS, Insurance applications, etc.)

- \$15.00 per year per diagnosis. (This \$15 fee covers all forms submitted per diagnosis for one rolling calendar year.)

Elmhurst Clinic – ROI Department
172 Schiller Street
Elmhurst, IL 60126

Please direct all questions to the phone numbers below:
-For copies of medical records: 630-758-9719
-For forms completion: 630-834-1120 extension 79204



Dear Patient:

To obtain a copy of your medical records or protected health information (PHI), please fill out an Elmhurst Clinic Release of Information Authorization form. We do charge a fee for the copying of your records or Protected Health Information (PHI). The fee schedule is as follows:

- \$.50 per page for pages 1-50
- \$.25 per page for pages in excess of 50
- Charges less than \$3 (5 pages) will be waived
- Maximum charge not to exceed \$50

Payment may be made by cash, check (made out to the Elmhurst Clinic) or by Visa, MasterCard or Discover. We will process your request, whenever possible, within 30 days.

Authorizations and payment may be sent to:

Elmhurst Clinic
Attention: ROI Department
172 Schiller
Elmhurst, IL 60126

Please use the section below to send credit card information along with your Elmhurst Clinic Release of Information Authorization form.

If you have any questions, please contact our Release of Information representatives located at our Schiller facility at (630) 758-9719 or fax at (630) 941-2637. ROI is available to help you Monday through Friday 8:00 – 4:00.

Thank you.

_____ **Visa** **MasterCard** **Discover**

Name on card _____

Card number _____

*Notice! For all credit cards, please include the 4 digits on the back of your card:

Expiration date _____ / _____ / _____ **Amount \$** _____

Signature _____

Patient name (if different than above) _____

(For Office Use Only)

MR#: _____

4. I understand that the information to be released may include information relating to the diagnosis and/or treatment of acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental and/or behavioral health, drug and/or alcohol abuse. Please exclude the following information:

5. I understand that I have a right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing and present my written revocation to the Release of Information (R.O.I) Department. I understand that the revocation will not apply to information that has already been released.

6. I understand that I have a right to inspect and/or receive a copy of the medical information to be released and also receive a copy of this authorization form.

7. I understand that there may be circumstances that would allow Elmhurst Memorial Healthcare to charge a reasonable fee for making copies, completing forms, and for postage of the information requested on this authorization.

8. If no prior notice to revoke this authorization is received, this authorization will expire on _____ but the expiration date will not exceed 1 year from the date the form is signed. Date

9. I further understand that the information disclosed may be redisclosed by the recipient and may no longer be protected by the federal privacy confidentiality rules.

10. I may refuse to sign this authorization and I understand my refusal to sign will not affect my ability to obtain treatment.

11. _____ _____
Signature of Patient or Legal Representative Date

12. _____
Printed Name of Legal Representative (if other than patient)

13. Relationship to Patient (if other than patient): Spouse Parent Power of Attorney
 Other _____

14. _____ _____
Signature of Witness (if applicable) or Date
Signature of Staff Member Present During Review

For Office Use Only

**** Elmhurst clinic staff: Please fill out the bottom portion and send to ROI department via interoffice mail. ****

Date ____/____/____ Request completed Payment Received:\$ _____

Completed By (Staff Name Printed) _____ Dept: _____

Staff signature _____

8-11-08