Riveredge Hospital

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Maiden/Prior Names: _____ Current Phone #: _____
Current Address: _____ Last 4 of SS#: _____

To be released to or requested from:

☐ Self (address above)

☐ _____ (____)_____ _____
Agency/Organization Telephone Number Street Address

_____ (____)_____ _____
Name / Attention to Fax Number City State Zip Code

Via (only when released to): ☐ Mail ☐ Fax ☐ Pick-up ☐ Email: _____
☐ Verbal Exchange of Information ONLY

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☐ Other: _____

Dates of Service Requested: _____

☐ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

☐ **I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ Continuity/Transition of Care Packet
☐ Psychiatric Evaluation
☐ History and Physical
☐ Discharge Summary
☐ Progress Notes
☐ Physician Orders
☐ Lab/Diagnostic Reports
☐ HIV Test Results and AIDS Treatment Records
☐ Other: _____

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire <u>one year</u> from signature date)

This form must be completed in full before signing:

_____ _____ _____ _____
Patient's signature (required for ages 12 and older) Date Signed Parent/Legal Guardian signature (if applicable) Relationship to Patient

_____ _____
Witness signature/Credentials Date Signed

This authorization is intended to allow Riveredge Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

_____ _____
Revocation Signature Date/Time

Patient Medical Record Copy Fee Notice

Riveredge Hospital has contracted Vital Records Control (VRC) to process valid requests for copies of medical records. To request your medical records, you may complete a **Release of Information Form.** These forms are available at your physician's office or you may contact VRC for a copy. Requests for copies of medical records are subject to reproduction fees in accordance with federal and state regulations. You are hereby notified in advance of said fees and by submitting this request you are accepting these fees and authorizing the provider/ VRC to process your request for records. An invoice will be sent to you once your request has been processed.

HITECH/Patient Access Requests - If a patient is requesting their own records for personal reasons (any request where records are sent directly to the patient or their personal representative), the patient will be charged. The fees are as follows:

Patient rates for records	State of IL/3rd Party Rates
Fees may include: • Minimum $6.50 Flat fee for 375 pages or less • $0.02/page average labor after the first 375 pages • $6.50 per CD if applicable • Plus postage if applicable • $25 for certification service if applicable	Fees may include: • $33.60/Handling charge • $1.26 per page for pages 1 through 25 • $0.84 per page for pages 26 through 50 • $0.42 per page for pages in excess of 51 • $25 per CD if applicable • $25 for certification service if applicable

Records sent directly to or requested by 3rd parties (attorney's, insurance companies, copy service's, etc.) will be subject to the state regulated fee schedule. Your completed request form may be submitted to your doctor for processing. The request may also be faxed or sent via email to the fax and email address listed below.

Fax Completed Requests Form To: (312) 836-7919
Email To: neintake@vrcnetwork.com

For status of a record request contact:
Vital Records Control
PO Box 11407
Birmingham, AL 35246
Phone: (312) 757-5020
Fax: (312-836-7919)
Email: NEcustomerservice@vrcnetwork.com

Fees should be remitted to VRC as directed on the invoice you receive. Checks should be made payable to Vital Records Control. You can also make a payment with a credit card online at https://pay.recordconnect.com or by calling VRC at (312) 757-5020.

Our standard processing time to respond to your request is 7-10 days. Please do not hesitate to contact us with any questions or concerns.