Patient Medical Record Request Fee Notice

Dear Patient,

Amita Health has contracted Midwest ROI, Inc. to process valid requests for copies of medical records. You must complete a Release of Information Form when requesting your medical records. (available at doctor’s office or here http://midwestroi.com/release-forms) Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations. You are here notified in advance of said fees and by submitting this request you are accepting these fees and authorizing the provider/Midwest ROI to process your request for records. An invoice will be sent to you once your request has been processed. Standard fees are as follows:

- If a patient is requesting their own records for personal reasons (any request initiated by the patient or their personal representative), the patient will be charged. Fees include labor for copying, supplies & postage. The fees are as follows:
  - $6.50 for 1-6 pages
  - $1.02 per page for pages 7-25 pages
  - $0.68 per page for pages 26-50
  - $0.34 per page for pages 51 and over
  - Plus shipping (if applicable). If no records are found based on the request received, the patient will be sent a no records notification free of charge.

- If a request for medical records is received where a third party is initiating a request for records on its own behalf (ex. insurance company, an attorney or copy service.), the third party will be charged the following fees:
  - $27.33 handling fee
  - $1.02 per page for pages 1-25
  - $0.68 per page for pages 26-50
  - $0.34 per page for pages 51 and over
  - plus shipping (if applicable). If no records are found based on the request received, the requester will be sent a no records notification and will be charged a handling fee.

YOU MAY HAVE TO WAIT 7-10 BUSINESS DAYS BEFORE YOUR REQUEST CAN BE PROCESSED.

PLEASE NOTE

- If patient is under 18 years of age, a parent or legal guardian can sign for the release of medical records. Documentation of guardianship is required
- If patient is 18 years of age or older, the patient must sign for their own records not the spouse.
- If patient is deceased, the next of kin may sign for the release of medical records. A copy of the death certificate and evidence of next of kin or documentation of executorship of the estate is required. If documentation is not available they must complete an authorized relative certification.
- If patient is unable to sign for their records, the patient's personal representative requesting the records must provide a healthcare power of attorney or proof of court ordered guardianship
- If patient is a minor who is emancipated, pregnant, or has a child. The minors parent or legal guardian cannot sign for the patient. Patient must sign for their own records.

(OMGWH)
Obstetrics, Midwifery & Gynecology

950 N. York Rd., Ste 102 Hinsdale IL,60521 p(630) 920-1347 f(630) 325-5946
Authorization to Request Release of Health Information

Patient Information:
Name: ____________________________
Date of Birth: ______________________
Address: __________________________
City: __________ State: _____ Zip: ______
Phone: ____________________________

Reason for Request:
□ Personal Copy □ Continuity of Care □ Legal/Insurance
□ Other (please specify) __________________________

Send Records By:
□ Mail □ Fax □ CD

Records to be Provided from: (Enter Your Doctors/Office information)
Facility/Provider: ________________________________
Address: ______________________________________
City: __________ State: _____ Zip: ______
Phone: __________________________
Fax: ________________________________

Send Records To:
Person/Facility/Agency: ________________________________
Address: ______________________________________
City: __________ State: _____ Zip: ______
Phone: __________________________
Fax: ________________________________

Information to be Disclosed:
□ Emergency Room Record □ Laboratory Report(s) □ Radiology Report(s) □ Immunization Record □ Itemized Billing Records
□ Office Notes □ Abstract/Summary □ Complete Record □ Prenatal Records
□ Test Result(s) of: __________________________
□ Other: __________________________

I understand that the information contained in my health record may include information relating to sexually transmitted diseases, acquired or mental health services, and treatment of alcohol and/or drug abuse. I authorize the release of all such items EXCEPT for those which I have marked below. By checking the boxes next to these items I understand that the following information will NOT be released.
□ Alcohol or Substance Abuse Records □ HIV and/or STD Testing and Results □ Mental Health Records □ Genetic Records

By signing this authorization form, I understand that:
• Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations and I was notified in advance of said fees. By submitting this request I am accepting all associated fees and authorizing the provider/Midwest ROI to process my request for records. An invoice will be sent to me once the request has been processed.
• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the facility at which this request is received. Revocation will not apply to information that has already been disclosed in response to this authorization.
• I have a right to inspect and copy the health information disclosed as a result of the delivery of this authorization
• Unless otherwise revoked, this authorization will expire on the following date/event/condition: __________________________. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
• Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
• Any disclosure of information carries with it the potential for re-disclosure, and the information may no longer be protected by federal confidentiality rules.
• If any, Consequences of Failure to consent: __________________________

Patient or Authorized Representative Signature ____________________________ Date ____________________________

Relationship to Patient (if applicable) ____________________________ Date ____________________________

Witness Signature required to release Mental Health Records __________________________________________ Date ____________________________