THE UNIVERSITY OF CHICAGO ORGANIZED HEALTH CARE ARRANGEMENT
REQUEST FOR PHI FOR USES OTHER THAN TREATMENT AND PAYMENT

The UC Organized Health Care Arrangement (or UC OHCA) consists of the University of Chicago Medicine and certain activities of the University of Chicago including physicians.

The University of Chicago Medicine and the University of Chicago Biological Sciences Division take seriously the privacy of our patients' health information and compliance with the HIPAA privacy rules. To obtain protected health information ("PHI") and/or electronic protected health information ("ePHI"), you must complete this form.
Please note that if this form is not complete, we will not be able to provide you with the PHI or ePHI you are seeking.

A. Your Information

Name: _____ Title: _____

Department: _____ Room #: _____

Extension: _____ Pager #: _____ Email:_____

Additional person(s) to be notified of approval/denial including Data Administrator (Name and Email):

_____

B. Information Requested

Patient name and medical record number (if more than 1 patient, attach a list):

_____ _____
Name *Medical Record Number*

- ❑ I am attaching a list of patients.
- ❑ Please use the following selection criteria to select patients:

- ❑ I request the following PHI/ePHI (be specific):
  - ❑ Patient name
  - ❑ Patient address
  - ❑ Patient age
  - ❑ Patient phone number
  - ❑ Financial class
  - ❑ Primary payer
  - ❑ Secondary payer
  - ❑ Billing information
  - ❑ Date of service
  - ❑ Attending MD/ID
  - ❑ Examining MD/ID
  - ❑ Patient condition
  - ❑ Patient diagnosis
  - ❑ Description of injuries
  - ❑ Patient's treatment
  - ❑ Photograph or video
  - ❑ Patient X-ray film(s)

  Other: (explain)

C. Purpose for Requested PHI

I will use the PHI/ePHI for the following HIPAA-compliant purpose(s) (be specific):

D. IRB Approval (if using PHI for research purposes)

Do you have IRB approval? ❑ Yes ❑ No
If "yes", please include a copy of your IRB approval letter in your submission.

E. ACKNOWLEDGEMENT. I understand and agree to comply with the University of Chicago Medicine's policies on storing, using, disclosing, and disposing of requested PHI. ❑ Yes ❑ No

I certify that I will not use or disclose the PHI or ePHI for any purpose other than the purpose stated above and that required patient authorizations have been obtained. I understand that I may be subject to sanctions if I use or disclose PHI contrary to that stated on this form.

_____ _____, 20___
Signature *Date*

Last Updated: August 2012