



**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 Hospitals, certain activities of the University of Chicago including physicians, and the UCHHS Regional Doctors Offices. Each of these is called a UC Organization.

The University of Chicago Medical Center takes seriously the privacy and security of our patients' health information and compliance with the HIPAA privacy and security 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.**

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Department:** \_\_\_\_\_ **Room #:** \_\_\_\_\_

**Extension:** \_\_\_\_\_ **Pager #:** \_\_\_\_\_

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):
 

<input type="checkbox"/> Patient name	<input type="checkbox"/> Primary payer	<input type="checkbox"/> Patient condition
<input type="checkbox"/> Patient address	<input type="checkbox"/> Secondary payer	<input type="checkbox"/> Patient diagnosis
<input type="checkbox"/> Patient age	<input type="checkbox"/> Billing information	<input type="checkbox"/> Description of injuries
<input type="checkbox"/> Patient phone number	<input type="checkbox"/> Date of service	<input type="checkbox"/> Patient's treatment
<input type="checkbox"/> Financial class	<input type="checkbox"/> Attending MD/ID	<input type="checkbox"/> Photograph or video
	<input type="checkbox"/> Examining MD/ID	<input type="checkbox"/> Patient X-ray film(s)
<input type="checkbox"/> Other: (explain)		

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

\_\_\_\_\_

\_\_\_\_\_

***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 or ePHI contrary to that stated on this form.***

\_\_\_\_\_, 200\_\_\_\_  
*Signature* *Date*

*Last Updated: January 22, 2007*