TELEPHONE REQUEST AND AUTHORIZATION TO COPY BILLING INFORMATION

This form is used when the patient [or the patient's personal representative*] requests over the telephone that billing information be sent to the address that we have on record.

Remember: Patients' billing information is confidential, protected by various state and federal laws.

Patient's Name: _____
Last First Middle
Medical Record Number: _____
Home Telephone: _____ **Date of Birth:** _____

1. Verify that the person who is on the telephone is who he/she says he/she is:

Please suggest ways to verify—should we not require the personal representative to present some type of proof? Is that too burdensome?

2. What are the dates of treatment for which he/she wants the billing records: _____

3. What are the facilities from which he/she wants the billing records:
____ The University of Chicago Hospitals
____ The following clinic(s): _____
____ The following regional doctor's office: _____
____ The Friend Family Health Center—Hyde Park

4. Notify the patient that If the billing information sought is about a mental illness or developmental disability, HIV/AIDS testing or treatment, communicable diseases, venereal disease(s), substance (i.e., alcohol or drug) abuse, abuse of an adult with a disability, sexual assault, child abuse and neglect, or genetic testing, then the patient must submit a written authorization.

5. Tell the patient
- "We will send the information to the following address (*read the address that you have on record*)."
- If you want to change the address where your information is sent to or if you have any questions or concerns about the confidentiality of your records, you can contact the **Privacy Office, Telephone Number: (773) 834-1183.**

_____ _____
Signature of Person who Took the Information *Date*

** The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.*