MIDWEST ROI
Secure health record fulfillment

Practice Closure Record Request Fee Notice 2018

Dear Patient,

Midwest Center for Women's HealthCare has contracted Midwest ROI, Inc. to process valid requests for copies of medical records. Your doctors office has now closed or is no longer part of Midwest Center for Women's HealthCare. To continue your care, we encourage you to see a Midwest Center for Women's HealthCare provider by going to https://www.mcwhc.com to find a new doctor. Your records can easily be transferred within Midwest Center for Women's HealthCare network at no charge.

If you choose to leave Midwest Center for Women's HealthCare you can request records to be sent to your new provider or your new provider can request records on your behalf at no charge. If you would like to request a personal copy of records you can do so at no charge.

To initiate a request for records, please complete the **Release of Information Form (pg.2)** You as the requester must specify exactly what records are needed, be sure to include your complete name, address, phone number as well as the recipients information.

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.
- If patient is 18 years of age or older, the patient must sign for their own records.
- If patient is deceased, the next of kin may sign for the patient with identification. A copy of the death certificate along with either court documents stating that they are the executor of the estate or 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.
- If patient is a female and is under 18 years of age and is pregnant, a parent or legal guardian cannot sign for the patient. Patient must sign for her own records.

You can submit your request electronically or by mail to the address listed below.
Email to: customerservice@midwestroi.com
Fax to: 312-284-8863
If you have questions or for request status call us at:

312-216-0911 EXT: 124

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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 ☐Other: _____

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: _____
Email: _____

Information to be Disclosed: **Dates of Service requested: ____/____/____ To ____/____/____**

☐ 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 understand that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information included in an email can be intercepted and read by other parties besides the person to whom it is addressed. The provider/Midwest ROI has notified me of the risks and will not be held liable if I choose to have my records sent by email.
- 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