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ROSECRANCE AND AFFILIATES
Instructions for Obtaining Copies of Medical Records

Please ensure all fields are complete, legible, and **sign** and **date** the form. Failure to properly complete each field may result in a delay in sending out the requested records. Requests are completed in the order of receipt and can take up to 30 days for completion unless notification of an extension is received. Any request may be granted or denied. It is understood that if this request is denied, a request for a review of the denial is permitted if requested.

Client and Requestor Information Print the client's full/legal name and any other names that records may be under while client was in treatment (e.g., client's maiden name). If you are requesting records that are not your own, please also include your name, organization (if applicable), and contact information.

> NOTE: Be sure to include the method for which you want the information to be delivered. (i.e., physical address for mail, fax number for fax or email address for email.)

Requested Information and Timeframe/Dates of service: Please indicate specifically what records are needed and provide a date range for the records being requested. (ex. 1/1/2024-3/2/2024)

Return the completed, signed form as follows:
Email: medicalrecords@rosecrance.org
Fax: (815)-720-5089
Mail: (below address)

Illinois:
Rosecrance Behavioral Health
Attn: Medical Records Department
1021 N. Mulford Road
Rockford, IL 61107

Iowa:
Rosecrance Jackson Centers
Attn: Medical Records Department
800 5th Street
Sioux City, IA 51101

Fees: There may be a processing fee. Fees depend on the number of pages copied and are assessed in accordance with state and federal regulations. For more information on fees please visit our website at www.rosecrance.org.

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ROSECRANCE AND AFFILIATES
Authorization to Disclose Medical Records

Client Name: _____ Date of Birth: _____

Address: _____

Email: _____ Phone Number: _____

By signing this document, I authorize the third party listed below to access my medical records using the delivery method(s) I have selected.

Requestor Name (*if different from client*): _____

Associated Company/Organization: _____

Phone Number: _____Fax Number: _____

Email Address: _____

How would you like to receive your request? ☐ Email ☐ Mail ☐ Fax ☐ Pick Up (in-person)

Purpose of Disclosure? ☐ Client Request ☐ Legal ☐ Continuing Care ☐ Insurance

☐ Other (please note): _____

Dates of information requested *(service dates)*: _____ to _____
Start End

Check All Information to be disclosed: ☐ All Listed

☐ Assessment Summary and Recommendations/IMCANS
☐ Medical Information (ex. physical exam, medications)
☐ Psych. Evaluation(s)/Notes
☐ Treatment Plan(s)
☐ Other (please specify): _____
☐ Discharge Summaries
☐ Toxicology/Lab Reports
☐ Diagnosis Information
☐ Progress Notes

Client Agreement:

I understand that the confidentiality of behavioral health patient records are protected by HIPAA, 42 CFR Part 2, and all applicable state confidentiality laws. I understand that if I refuse to sign this authorization, no information will be released, and I will not be denied treatment. Rosecrance has the right to disclose information as permitted by this authorization in any manner that is deemed appropriate and consistent with applicable law, this includes verbal, paper, and electronic submissions. I understand that I have the right to revoke this authorization at any time. This authorization will expire in one year from the date signed unless I request an earlier expiration.

_____
Client Signature Date

_____
Parent, guardian, or personal representative Signature Date

(in Illinois: Clients aged 12-17 years old are requested to sign and date with co-signature of parent/legal guardian)