UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy Privacy Form

UChicago Medicine AdventHealth
Specialty Pharmacy
500 Remington Blvd
Bolingbrook, IL 60440
Phone: 630-856-3991
Toll Free: 833-670-7171

The HIPAA regulations went into effect on April 1, 2024, and as a retail pharmacy, we are required **by law** to provide you with a notice of our Privacy Practices. We must have your signature on file to state that you have received the attached notice. After you have read the notice, please sign and mail this card back to **UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy**. We appreciate prompt return of your signature.

Thank you for your cooperation in this matter.

Sincerely,

UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy

Print Name: _____

Signature: _____

Acknowledgement of Receipt *(Return via mail, email or fax)*

Name_____DOB: _____ Phone: _____

Address: _____

Please confirm that you received the UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy Welcome Packet by signing and sending back to us the following.

- Patient Acknowledgement & Assignment of Benefits
- HIPAA Rights of Access
- Credit Card Authorization

Completed forms may be mailed to:

UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy
500 Remington Blvd,
Bolingbrook, IL 60440

FAX: 1-630-856-3992 | Email: GLR.SPS@adventhealth.com

With my signature below, I hereby acknowledge receipt of the above-mentioned forms.

_____ _____

Patient Signature Date

Assignment of Benefits

I hereby authorize UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy to bill my insurance carrier or any other payment source. I assign all benefits and authorize payment to UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy otherwise payable for me for all claims for such services provided or submitted prior to, or after, the date provided on this form. I understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. This assignment and authorization in no way releases me from said responsibility and imposes no obligation on UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy to collect money on my behalf.

I have read, understand and agree to the Assignment of Benefits.

_____ _____

Patient Signature Date

_____

Patient Name

_____

Patient Address

HIPAA Right of Access / Representative Form for Family Member/Friend

By signing below, I understand that I am identifying, authorizing, and granting permission to the Personal Representative identified below to have authority to access my protected health information (PHI) and to assist in my treatment by UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy as described below:

Representative's Name: _____ Relationship to Patient:_____

Address: _____ Telephone #:_____

Health Information to be Disclosed to the Representative upon Request:

- I understand that by completing this form I am allowing the release of any and all information held by UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy (including, but not limited to information about my medications, medical condition, billing records, and drug handouts) to be shared with and disclosed to my Personal Representative.
- I understand the information released could relate to the following: Family Planning/Abortion, Alcohol, drug, or substance abuse information, AIDS, HIV-related information (including AIDS related testing and results), Mental Health, Sexually Transmitted Disease/Venereal Disease information, Genetic information, and Tuberculosis.
- I understand that any information disclosed pursuant to this form may be re-disclosed to other parties and no longer protected by the privacy regulations.

Duration of Access:

- I understand the designated Representative will have access to my information unless and until access is revoked by me.
- I understand that I may revoke this form and designation at any time by notifying UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy in writing. If the authorization is revoked, it will not have any effect on any actions taken by UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy prior to their receipt of the revocation.

I understand that signing this form is voluntary and that I do not have to sign this form. I understand that signing this form will not affect my ability to obtain treatment from UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy, any payment for treatment or enrollment or eligibility for benefits.

Signature of Patient: _____Date: _____

UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy *Credit Card Authorization (Return via mail or FAX)*

UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy
500 Remington Blvd, Bolingbrook, IL 60440
Phone: 833-670-7171 | FAX: 630-856-3992 | Email: GLR.SPS@adventhealth.com

Date: _____

Name: _____

DOB: _____

Account Type (circle one): Visa MasterCard AMEX

Credit Card Name: _____

Last Four Digits of Card Number:_____ Expiration Date: _____

V-Code (3 digits on back) : _____

_____

Signature as it appears on card

Please sign form and return to
UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy
at above address or
FAX to 630-856-3992

Thank you,

UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy

Pharmacy Record Release Form *(Return via mail or fax)*

☐ Paper (I understand that all records will be mailed unless specified)

☐ Electronic: _____

☐ Fax: _____

The purpose of this request:

☐ Personal Request ☐ Treatment (Continued Care)

☐ Other: _____

Request access and/or disclosure of Patient Prescription records for the following dates of service:

_____

Patient Signature: _____ Printed Patient Name: _____

LAP Signature: _____ Print Name: _____

Witness Signature: _____ Print Name: _____

Date: _____

Phone: _____

Request for Access has been:

☐ Granted ☐ Partially Denied ☐ Denied

If access is denied and patient requests review of denial, contact the Release of Information office below. Medical Records released/accessed:

Date: _____ By: _____

Send to Release of Information:
Email: : GLR.SPS@adventhealth.com or **Fax:** 630-856-3992
Mailing Address: UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy
500 Remington Blvd, Bolingbrook, IL 60440 | Phone: 833-670-7171

Patient Concern and Complaint Form

If you are not completely satisfied with the care or services we have provided, we want to know about it. Call our Call Center with any concerns or problems with your medications or services at **833-670-7171.** If you wish to file a written complaint, you may do so using this form. If a complaint cannot be resolved verbally over the phone, it will be addressed via our company's policies and procedures regarding complaints through a formal process.

Please mail or email the form to us.

Completed forms may be mailed to:
UChicago Medicine AdventHealth Bolingbrook Specialty Pharmacy
500 Remington Blvd, Bolingbrook, IL 60440 Bolingbrook, IL 60440
or Emailed to: GLR.SPS@AdventHealth.com or **Faxed to:** 630-856-3992.

Patient's Name: _____ Date: _____

Regarding: _____

_____

_____

Employee Involved (if applicable):_____

Nature of problem: _____

_____

_____

_____

_____

_____

_____

You or your representative may also file a complaint with the Illinois Department of Public Health at 525 West Jefferson Street, Springfield, IL 62761-0001.

Phone: 800-252-4343. **TTY *(hearing impaired use only)*:** 800-547-0466. **Fax:** 217-524-2913.