



# Village of Chicago Ridge

## FREEDOM OF INFORMATION ACT (FOIA) REQUEST FORM

Submit your FOIA request to:

**Village/Fire Dep.:** Village of Chicago Ridge  
Attn: FOIA Officer  
10455 S Ridgeland Ave.  
Chicago Ridge, IL 60415  
**Phone:** (708) 425-7700  
**Fax:** (708) 425-9942  
**E-mail:** acahue@chicagoridge.org

**Police Department:** Chicago Ridge Police Dep.  
Attn: FOIA Officer  
10425 S Ridgeland Ave.  
Chicago Ridge, IL 60415  
**Phone:** (708) 425-7831  
**Fax:** (708) 857-4460  
**E-mail:** atrygar@chicagoridgepolice.org

<input type="checkbox"/> VH <input type="checkbox"/> PD <input type="checkbox"/> FD Log # _____ Received: _____ Responded: _____ <b>OFFICE USE ONLY</b>
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Name of Requester _____	Phone _____
Address _____	
E-Mail _____	Fax _____
Signature _____	Date _____

This is a request for information under the Illinois Freedom of Information Act, 5 ILCS 140/1, et seq. I request the following document or documents containing the following information:

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Please provide (choose one):

- Paper copies of documents  
  Electronic file (if available) or  
  Inspect documents in person

Respond via (choose one):

- E-mail  
  Mail  
  Fax or  
  Pick up @ Village Hall  
  Pick up @ Police Department

Purpose of your request:    Non-Commercial (5 business days)    Commercial (21 business days)

\*A "commercial purpose" is defined under the Act as the use of any part of a public record or records, or information derived from public records, in any form for sale, resale, or solicitation or advertisement for sales or services. **Please be advised that misrepresentation of the purpose of a Request is a violation of the Act.\***

I am willing to pay fees for this request up to a maximum of \$ \_\_\_\_\_. If more than this limit, inform me first.

**Black ink legal size copies – first 50 pages free & \$0.15 per page thereafter.**

**Actual cost applies to large format prints and/or PDF scans.**

**Additional charges apply for electronic media (eq. CD, DVD, Flash Drive) if not provided by requester.**

**PD Incident reports & FD Fire reports - free of charge / PD ACCIDENT reports available at crashdocs.org (fee applies).**

<b>Office Use Only:</b> Request received by _____	Date _____/_____/_____
Responded via: <input type="checkbox"/> Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> Pick up	Initials _____   Date _____/_____/_____

**Chicago Ridge Fire Department**  
**REQUEST FOR ACCOUNTING OF DISCLOSURES OF**  
**PROTECTED HEALTH INFORMATION**

As required by the Health Information Portability and Accountability Act of 1996 you have the right to request and accounting of disclosures of health information that pertains to you.

**REQUEST SECTION**

I, \_\_\_\_\_ hereby request an accounting of disclosures of my  
protected health information that have occurred over the last \_\_\_\_\_.

(Up to 6 years)

Signature \_\_\_\_\_

Date \_\_\_\_\_

**REQUEST PROCESSING SECTION – INTERNAL USE ONLY**

This section is to be completed by the reviewer:

Date Received: \_\_\_\_\_ Privacy Officer: \_\_\_\_\_

Review Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

The requested disclosure accounting was processed on \_\_\_\_\_

**Chicago Ridge Fire Department  
Patient Request  
For  
Access to Health Information**

**Patient Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Date of Incident:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

***Patient Rights:*** As a patient, you have the right to access, copy, or inspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described on our Notice of Privacy Practices which you have received.

To better allow us to process your request, please indicate the type of request you are making on this form:  
(check all that apply)

\_\_\_\_\_ ACCESS TO REVIEW MY HEALTH INFORMATION

\_\_\_\_\_ ACCESS TO OBTAIN COPIES OF MY HEALTH INFORMATION

\_\_\_\_\_ ACCESS TO REQUEST AN ACCOUNTING OF HOW MY PROTECTED HEALTH INFORMATION HAS BEEN USED AND DISCLOSED TO OTHERS.

\_\_\_\_\_ ACCESS AND REQUEST RESTRICTIONS ON THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION.

**Signature** \_\_\_\_\_ **Request Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**NOTE:** (There will be a fee charged for Protected Health Information Access Requests)

**CHICAGO RIDGE FIRE DEPARTMENT  
REQUEST FOR RESTRICTION ON USE & DISCLOSURE OF  
MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone Number (Day) \_\_\_\_\_

Phone Number (Evening) \_\_\_\_\_

1) Medical Information to be restricted \_\_\_\_\_  
\_\_\_\_\_

2) Nature of Restriction \_\_\_\_\_  
\_\_\_\_\_

3) Medical Information to be communicated Confidentially: \_\_\_\_\_  
\_\_\_\_\_

4) Alternative Location/Address Telephone Number \_\_\_\_\_  
\_\_\_\_\_

**TO OUR PATIENTS:** You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree to your requested restrictions. If we do agree to the requested restriction, we will abide by your restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you (1) specify the alternative location, address, or telephone number and/or the alternative means of contact and (2) you agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Request for Restriction Accepted \_\_\_\_\_

Request for Restriction Denied \_\_\_\_\_

Request to Communicate Confidentially Accepted \_\_\_\_\_

Request to Communicate Confidentially Denied \_\_\_\_\_

This Request for Restriction and Confidential Communication Form is to be made a part of the medical record of:

Patient Name: \_\_\_\_\_