☐VH ☐PD ☐FD
Log # _____
**Received:**
___/___/___
**Responded:**
___/___/___
**OFFICE USE ONLY**

# 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
mkrivensky@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

**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:**

_____

_____

_____

***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 formant 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).**

**Office Use Only:** Request received by_____ Date____/____/____

Responded via: ☐ Mail ☐ E-mail ☐ Fax ☐ Phone ☐ 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,_____hearby 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:_____