ADVOCATE HEALTH

Third Party Electronic Data Request

This form is intended solely for authorized representatives of **HIPAA covered entities, healthcare providers or developers of certified HIT** inquiring about data integration/access, batch files or feeds from Advocate Health (AH). If your inquiry meets these criteria, you will receive a response within 10 business days.

If you are a **patient** requesting access to your medical records:

Patients and their authorized representatives can obtain access to their records by:

- Patient Portal:
  - IL, WI: LiveWell application
  - NC, GA, AL, SC: MyAtriumHealth application
- Application Programming Interface (API) such as Apple Health
  (Note: API must be on approved AH list)
- Request from HIM Dept. records in physical media format (*e.g.*, paper, cd or usb) or email. For more information contact:
  - WI/IL Locations**:** call 414-979-4590 or email: AuroraReleaseofInfo@aah.org
  - NC/GA Locations: call 844-383-2109 or email: MedicalRecordsROI@atriumhealth.org

If you are a **health care provider**:

Please Note: Advocate Health contributes clinical data to the following Health Information Exchanges, that support the flow of health information among clinics, hospitals, labs, and others, *regardless of the type of EHR systems they may use.*

Completion of this form is not required to access Advocate Health data via these HIE's.

eHealth Exchange Network	CareQuality	WISHIN	Medical Home Network (MHN)
https://ehealthexchange.org/how-to-join/	https://carequality.org/	https://wishin.org/	https://www.medicalhomenetwork.org/
Organization subscription and Annual Network Participation Fee required. Requestors may obtain information from AH on becoming a participating member to integrate their EMR with the exchange and experience more benefit than just exchanging info with AH. *Subject to Implementer participation and eHealth Exchange Network costs.*	A non-profit, national-level, consensus-built, interoperability framework to enable exchange between and among health information networks and service platforms. It supports secure access to health information across diverse networks, including EHR vendors, record locator service providers, health information exchanges, and others. Connectivity is governed by technical and policy agreements developed and maintained by a broad group of industry and government stakeholders. *Subject to Implementer participation and eHealth Exchange Network costs.*	WISHIN is Wisconsin's state-designated entity for HIE. It is responsible for developing HIE capability throughout the state. WISHIN's products and services allow health care providers to securely share a patient's medical information with other health care providers who have seen the patient—even if those providers are not part of the same practice or health system. Requestors may obtain information from AH on becoming a participating member to integrate their EMR with the exchange and benefit more than just exchanging data with AH. *Subject to participation fees.*	MHN is a not-for-profit collaborative that creates a structured approach to care management by providing appropriate tools, processes, staffing and sharing of care plans. Its team-based model of care is supported by innovative technology that virtually integrates disparate healthcare entities to enable collaborative care management across a network consisting of 23 hospitals and over 300 primary care entities in the greater Chicago area. *Subject to participation fees.*

Instructions: We encourage requestors to utilize one of the above HIEs. However, if you require data access in an alternate electronic form please submit completed request form and/or questions to AAH-InfoBlocking-Interoperability@aah.org.

ADVOCATEHEALTH

Part 1: Requestor Information **required entry*

*Company Name:	
	☐ Health Care Provider ☐ Health Plan ☐ HIPAA Business Associate ☐ Other *(please describe):*
Street Address:	
City, State, Zip Code:	
*Contact Name:	
Title:	
*Phone:	
Fax:	
*Email:	
EMR Application:	
EMR Vendor:	
EMR IT Contact:	

Part 2: Requestor Organization

1. Organization Type

Governmental:
- ☐ Federal
- ☐ State:_____
- ☐ Local

Non-Governmental: (*select all that apply)*
- ☐ Health Care Provider Group
- ☐ TEFCA Participant
- ☐ Health Information Exchange (HIE)
  - ☐ State HIE
  - ☐ Regional HIE
  - ☐ Other HIE
- ☐ Advocate Health Affiliate
- ☐ Health Plan or Third-Party Administrator (TPA) for Health Plan (*If TPA, provide a copy of BAA & purpose for request)*
- ☐ Vendor *(provide name(s) of covered entity requesting on behalf of & include copy of BAA)*
- ☐ Vendor Intermediary
- ☐ Value-Based Care or Affordable Care Organization

Other *(please describe):*

_____

2. Patient Care Organization Background: *(as applicable)*

Number of Hospitals & Clinics: *(include number of providers)*	

Other Provider Organizations: (e.g. Nursing home, Hospice, Home Health, etc.) *(include number of AH patients or referrals annually).*	

Part 3: Access or Data Exchange Type **required entry*

Provide as much information as possible about the data being requested (e.g. Patient history for continuing care, HEDIS, Emergency Care, lab results, etc.)

Please do not include on form or attach any protected health information (PHI).

***Business Need:**	
***Advocate Health division you are requesting data from:**	☐ Illinois ☐ Wisconsin ☐ North Carolina/Georgia
***Advocate Health Sponsor:** (to establish a relationship with AH) *(include name, email, dept and tax id)*	☐ Physician ☐ Advocate Health Manager/Director _____ _____ Tax ID: _____
***Request Type:** *(e.g. discrete data, reports etc.)*	
***Content Request:** *(e.g. lab results, progress notes etc.)*	

***Request Frequency:** *(if applicable)*	☐ One Time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other *(please describe):* _____ _____
***Report Format:** *(if applicable)*	☐ .CSV ☐ .PDF ☐ Interface ☐ Other *(please describe):* _____ _____
Supporting Documents: *(Note: If vendor or vendor intermediary, provide BAA and/or other supporting documentation authorizing data access)*	

☐ I attest that I am authorized to request and receive the above listed electronic health information (EHI) on behalf of the entity, organization, and/or individual indicated on this form, and that I will comply with all applicable state and federal privacy laws created for the purposes of protecting individual and personal privacy.

***Electronic Signature:**	
Date: *(mm/dd/yyyy)*	

Submit completed form and/or questions to AAH-InfoBlocking-Interoperability@aah.org.

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