UNIVERSITY *of* ROCHESTER MEDICAL CENTER

& Affiliates

Facility: ______________________
Department Name: ______________________
Address: ______________________
____
Phone #: ______________________
Fax #: ______________________

PATIENT/PERSONAL REPRESENTATIVE REQUEST TO INSPECT AND/OR OBTAIN PHOTOCOPIES OF HEALTH INFORMATION

Request is hereby made for access to ☐ **medical** ☐ **mental health** information regarding:

Patient's name: ______________________ Date of Birth: ______________
Address: ______________________
City/State/Zip Code: ______________________
Patient's daytime phone ( ) - ______________________

What type of access are you requesting?

☐ MyChart — Upload to MyChart free. Available for 30 days within MyChart. Download or print this information to a secure location prior to the end of 30 days for ongoing access.

☐ View — You will be notified within 10 days on how to schedule an appointment with our staff. When viewing, you may request items for copying.

☐ Electronic Copy — You should receive notification within 30 days from our release of information service, Verisma, of cost of the copies.

☐ Paper Copy — You should receive notification within 30 days from our release of information service, Verisma, of cost of the copies.
PLEASE CHECK HERE ☐ IF YOU NEED TO PICKUP YOUR RECORDS.

Type of record: *Check all that apply:*

☐ Inpatient: **DATES** ______________________ Regarding: ______________

☐ Outpatient/Office visits: **DATE(S)** ______________________ Regarding: ______________

What information would you like to access? *Check only ONE option:*

☐ Complete records for the date specified above
☐ Abstract for the date specified above *(abstract=discharge summary, history/physical, consults, x-ray reports, labs, operative reports, pathology reports, diagnostics.)*
☐ Radiology ☐ Films ☐ Reports for DATES: ______________________
☐ Other: ______________________

NOTE: If you want this information ☐ **mailed** and/or ☐ **billed** to a different person (i.e. Relative/Friend) please complete this section.

Name: ______________________ Daytime phone #: ( )- ______________
Address: ______________________
City/State/Zip Code: ______________________

If access to my medical record is denied pursuant to New York State Public Health Law or Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations, I will be notified and provided information on the appeal process.

Signature of Patient or Representative: ______________________ Date: __________
Relationship to Patient (if requester is not the patient) ______________________
Co-Signature of Minor Patient (ages 12-17)*: ______________________

A minor's signature (ages 12-17) is required for the following records: HIV-related information, sexually related treatment, mental health care, or substance abuse diagnosis and treatment.