

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

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

**What type of access are you requesting?**

- ☐ View      You will be contacted within 10 days to schedule an appointment with our staff. When viewing, you may request items for copying.
- ☐ Electronic Copy      You will receive a **secure email** with requested information within 30 days.  
An **email consent form is required.**  
Email Address: \_\_\_\_\_
- ☐ Paper Copy (mailed)      You will receive copies of requested information within 30 days.
- ☐ Paper Copy (pick-up)      You may pick up paper copies in person 14 days after signing this request.

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

- ☐ Dental record release package (*Includes up to previous 3 years of visits including provider notes and the most current x-rays*)
- ☐ Specific data only from the following date: \_\_\_\_\_ **or** date range: \_\_\_\_\_
- ☐ X-Ray data only from the following date: \_\_\_\_\_ **or** date range: \_\_\_\_\_
- ☐ Other: \_\_\_\_\_

**NOTE:** If you want paper copies **mailed** to a Relative/Friend/other Representative, complete this section.  
(Please note that sensitive information may be contained in visit notes such as medical history, mental health or chemical dependency or HIV status).

Name: \_\_\_\_\_ Daytime phone #: (       ) \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip Code: \_\_\_\_\_

If access to my dental 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.**