UNIVERSITY of ROCHESTER MEDICAL CENTER
& Affiliates

Highland Hospital
Health Information Management Dept
1000 South Avenue, Box 55
Rochester, NY 14620
Phone: (585)341-6766 Fax: (585)341-8493

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.**