



& 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.