UR Medicine
Health Information Management (HIM) Department
601 Elmwood Avenue, Box 616 • Rochester, NY 14642-8616
Phone: (585) 275-2605 • Fax: (585) 273-1257 or (585) 424-2922

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

Patient's name (print): _____ 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 THE RECORDS WILL BE PICKED UP*

Type of record – The records requested are to include (*check all that apply*)

☐ Mental Health Treatment Records ☐ Alcohol/Drug Treatment Records

☐ FF Thompson Hospital ☐ Highland Hospital ☐ Jones Memorial Hospital ☐ Nicholas Noyes Hospital

☐ St. James Hospital ☐ Strong Memorial Hospital

☐ Inpatient: DATE(S): _____ Regarding: _____

☐ Outpatient/Office visits: DATE(S): _____ Regarding: _____

What information would you like to access? (*check ONE option*)

☐ Complete records for the date(s) specified above

☐ Abstract for the date(s) specified above
(abstract = discharge summary, history/physical, consults, x-ray reports, labs, operative reports, pathology reports, diagnostics)

☐ Radiology: ☐ Films ☐ Reports for DATE(S): _____

☐ Other: _____

Please complete the following section to ☐ mail and/or ☐ bill to a different person (relative/friend).

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 Patients (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.**