NYC HEALTH + HOSPITALS

Request for Access to Health Information

Patient Name: _____

DOB: ____/_____/_____

Medical Record Number: _____

Telephone Number: _____

NYC Health + Hospitals will use this form to document your request for access to your health information.

Access Requested: ☐ Copies ☐ Onsite Inspection

Format Requested: ☐ **Paper** ☐ **CD** ☐ **Email** ☐ **Other:** _____

Method of Release:

☐ Pickup/In Person ☐ E-mail to: _____

☐ Mail to: _____

INFORMATION BELOW IS REQUIRED FOR ALL REQUESTS

Information to be Accessed:

☐ Health Information (date(s)) _____ ☐ Radiology Reports (date(s)) _____

☐ Laboratory Test Results (date(s)) _____ ☐ Progress Notes (date(s)) _____

☐ Billing Records (date(s)): _____ ☐ My complete medical record

☐ Other (please specify): _____

The following information will not be released unless you specifically select each applicable type below:

☐ Substance Use Disorder Information ☐ Mental Health Information

☐ Genetic Testing Information ☐ HIV-Related Information

I understand that I have the right to access my health information in the form and format requested if readily producible in such form and format, and that if NYC Health + Hospitals cannot readily produce such health information in the form and format requested, I will be provided a readable hard copy form or such other form and format as mutually agreed upon.

I understand that if I request an electronic copy of my health information, it will be provided to me if readily producible in such form and format, or if not, in a readable electronic form and format as mutually agreed upon.

I understand that if I request on-site inspection of my health information that the respective Health Information Management Department is responsible for coordinating such inspection in a reasonable and timely fashion.

I understand that if I request copies of my health information, I may be charged a reasonable cost-based fee for such request and that any fee estimates will be provided to me prior to being charged. I also understand that my inability to pay may not be used as the sole reason to deny a request to access my health information.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: DATE/TIME:

IF NOT PATIENT, PRINT NAME, ADDRESS AND PHONE NUMBER OF PERSONAL REPRESENTATIVE:

RELATIONSHIP/AUTHORITY TO ACT ON BEHALF OF PATIENT:

NAME OF EMPLOYEE PROCESSING REQUEST: _____

EMPLOYEE SIGNATURE: _____ DATE/TIME: _____