Demann pou Jwenn Aksè nan Enfòmasyon sou Sante

Patient Name: ______________________________

DOB: ____/_____/_____

Medical Record Number: ______________________________

Telephone Number: ______________________________

NYC Health + Hospitals pral itilize fòm sa a pou dokimante demann ou an pou jwenn aksè ak enfòmasyon sou sante ou yo.

Tip Aksè yo Mande: ☐ Kopi ☐ Enspeksyon Sou Plas

Fòma ou Mande an: ☐ Papye ☐ CD ☐ Imèl ☐ Lòt: ______________________________

Metòd Divilgasyon:

☐ Pase Pran / Fizikman ☐ Voye pa Imel: ______________________________

☐ Voye pa lapòs nan: ______________________________

ENFÒMASYON KI ANBA A OBLIGATWA POU TOUT DEMANN YO

Ou pral Jwenn Aksè nan Enfòmasyon sa yo:

☐ Enfòmasyon sou Sante (dat(yo)) ________________

☐ Rezilta Tès Laboratwa (dat(yo)) ________________

☐ Dosye Faktirasyon (dat(yo)): ________________

☐ Lòt (tanpri presize): ______________________________

☐ Rapò Radyoloji (dat(yo)) ________________

☐ Nòt sou Pwogrè (dat(yo)) ________________

☐ Dosye medikal konplè m nan

Enfòmasyon ki annapre yo ap rete sekrè amwenske ou chwazi espesifikman chak tip ki aplikab anba la:

☐ Enfòmasyon sou Twoub ki lye ak Itilizasyon Sibstans (Dwòg / Alkòl)

☐ Enfòmasyon sou Tès Jenetik

☐ Enfòmasyon sou Sante Mantal

☐ Enfòmasyon ki Lye ak VIH

Mwen konprann mwen gen dwa pou mwen jwenn aksè nan enfòmasyon sou sante m yo nan fòm ak fòma mwen mande an depi yo pare pou yo pwodui yo nan fòm ak nan fòma sa a, epi si NYC Health + Hospitals pa ka pwodui tousuit enfòmasyon sa yo nan fòm ak nan fòma mwen mande an, y ap ban m yon kopi sou papye nan yon fòm ki lizib oswa nenpòt lòt fòm oswa fòma nou toude dakò sou li.

Mwen konprann si mwen mande yon kopi elektwonik enfòmasyon sou sante mwen yo, y ap banmwen l si li pare pou pwodui nan fòm ak fòma sa a, oswa sinon, nan yon fòm ak fòma ki lizib nou dakò sou li.

Mwen konprann si mwen mande yon enspeksyon sou plas enfòmasyon sou sante mwen yo, Depatman Jesyon Enfòmasyon sou Sante an responsab pou kowòdone yon enspeksyon konsa nan yon fason ki rezonab epi ki pa pran tan.

Mwen konprann si mwen mande kopi enfòmasyon sou sante mwen yo, yo ka fè m peye yon frè rezonab ki baze sou pri a pou yon demann konsa epi yo ap fè m konnen nenpòt estimasyon frè a anvan yo fè m peye l. Mwen konprann tou enkapasite m pou m peye ka pa sèvi kòm sèl grenn rezon pou yo refize yon demann pou jwenn aksè ak enfòmasyon sou sante mwen yo.

SIYATI PASYAN AN OSWA REPREZANTAN PÈSONÈL LI: DAT / LÈ:

SI OU PA PASYAN AN, EKRI NON, ADRÈS AK NIMEWO TELEFÒN REPREZANTAN PÈSONÈL LAN AN LÈT DETACHE:

RELASYON / OTORITE POU AJI NAN NON PASYAN AN:

NAME OF EMPLOYEE PROCESSING REQUEST: ______________________________

EMPLOYEE SIGNATURE: ______________________________ DATE/TIME: ________________

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: ______________