NYC HEALTH + HOSPITALS

健康信息访问申请书

Patient Name: _____

DOB: ____/_____/_____

Medical Record Number: _____

Telephone Number: _____

NYC Health + Hospitals 将使用此表格记录您针对个人健康信息的访问申请。

申请的访问方式： ☐ 副本 ☐ 现场查看

申请的格式： ☐ 纸质版本 ☐ CD ☐ 电子邮件 ☐ 其他：_____

披露方式：

☐ 自取 / 本人亲取 ☐ 发送电子邮件至：_____

☐ 邮寄至：_____

所有申请均需要填写以下信息

要访问的具体信息：

☐ 健康信息（日期）_____ ☐ 放射学报告（日期）_____

☐ 实验室检验结果（日期）_____ ☐ 病程记录（日期）_____

☐ 账单记录（日期）：_____ ☐ 我的完整病历

☐ 其他（请详细说明）：_____

以下信息仅在您特别勾选下方各适用条目时才会披露：

☐ 药物滥用障碍信息 ☐ 心理健康信息

☐ 基因检测信息 ☐ HIV 相关信息

我了解，我有权获取所申请的形式和格式的个人健康信息，前提是手边已有此类形式和格式可生成，如果 NYC Health + Hospitals 手边无法以我申请的形式和格式生成个人健康信息，将在双方同意的基础上为我提供可阅读的硬拷贝格式或此类其他形式和格式。

我了解，如果我申请电子版本的个人健康信息且手边可用该形式和格式生成信息，NYC Health + Hospitals 将为我提供；如果不能，将在双方同意的基础上以可阅读的电子格式和形式为我提供。

我了解，如果我申请现场查看个人健康信息，相应的健康信息管理部门将负责以合理、及时的方式进行协调。

我了解，如果我申请个人健康信息副本，我可能需要为此支付合理的成本费用，并且收费前会告知我所有预估费用。我亦明白，无法支付这类费用不会作为拒绝我的健康信息访问申请的唯一原因。

患者或个人代表签名： 日期 / 时间：

如果不是患者本人，请正楷填写个人代表的姓名、地址及电话号码：

与患者的关系 / 代患者行事的权限：

NAME OF EMPLOYEE PROCESSING REQUEST: _____

EMPLOYEE SIGNATURE: _____ DATE/TIME: _____

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: _____