Request for Release of Information

Radiology Only

PLEASE COMPLETE ALL FIELDS

Patient's Name: _____ Date of Birth: _____

Address: _____

City State Zip Code

Phone: _____ Email Address: _____

Who will disclose the information? HSS is authorized to disclose the information described below.

Who will use and/or receive the information? The person(s), or class of persons, authorized to use and/or receive the information:

Name: _____

Address: _____

City State Zip Code

Phone: _____ Fax: _____

Immediate Access to Images: You can access your images, notes, and reports through your online portal at www.hss.edu/myhss free of charge.

Please check all boxes that apply

I am requesting a copy of my **Radiology Report(s)** ☐ **and/or Radiology Image(s) on a CD** ☐ for my:

Exam Type(s): ☐ X-Ray ☐ CT ☐ MRI ☐ Bone Density ☐ Ultrasound

for exam date(s) _____

What is the purpose of the use or disclosure? (check where applicable)

☐ Patient's Request	☐ Medical Care	☐ Insurance
☐ Immunization	☐ Legal	☐ Other: _____
☐ Support for an application, claim or appeal for a government benefit or government program		

Request:

☐ I will personally pick up the disc ☐ Mail to me at the above address

Please see fee schedule:

Picking up disc(s) in person are $35 each Disc(s) to be mailed are $35 each (via FedEx Ground)

When will this authorization expire? One (1) year from date signed, unless a date / event is specified below:

_____

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Please fill out the form and return to us:

1. Hand deliver in office
2. Fax to: 646-714-6060 or 212-774-2327

***Copies can be picked up Monday-Friday from 8:00am - 4:40pm at our above listed address.**

According to Section 18 of the NY State Public Health Law, Hospital for Special Surgery is the custodian of all Radiographic Images and therefore must maintain originals. HSS is allowed to impose a reasonable charge for copies provided. The charges are up to $35.00 for a CD. An image viewer will be added for viewing on MAC / Apple.

For all other medical records go to your online portal at www.hss.edu/myhss or contact HSS Health Information Management Department via email at roirequest@hss.edu or call 646-797-8254.

Signature of Patient or Personal Representative*	Print Name of Patient or Personal Representative
Description of Personal Representative's Authority	Date

If you are making a request for records on behalf of a child (ages 12-17) – the child must authorize you to receive records on his/her behalf as required by NYS Public Health Law § 17 & 18.

Signature of Adolescent Patient	Date

OFFICE USE ONLY

MRN: _____ **Clerk Initials:** _____