Request for Access to Health Information

OFFICE USE ONLY

MRN: _____

Patient Name: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City State Zip Code

Email (for notification purposes only): _____ Telephone: _____

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

I would like to
- ☐ Access (inspect) my information maintained by HSS. (By appointment ONLY)
- ☐ Obtain a **PRINTED** copy of my information. (Includes Radiology Reports)
- ☐ Obtain an **ELECTRONIC** copy of my information. (CD)

The specific information I would like to access or receive a copy of:

Date(s) of Service: (What dates should be included)	**From Date:** ____/____/____ **To Date:** ____/____/____	
☐ Abstract Records (H&P, Discharge Summary, Operative Report, Anesthesia, Implant Records, Physician Office Note, Clinic Notes, Consult Note, Lab reports, Imaging Reports)	☐ HSS Physician Office Records Physician's Name: _____	
☐ Billing Statements	☐ EKG Reports	☐ Operative Reports
☐ Consultations	☐ History & Physical Exams	☐ Pathology Reports
☐ Discharge Summary	☐ HIV/AIDS Test Results	☐ Progress Notes
☐ Radiology and/or MRI Reports	☐ Laboratory Reports	☐ Rehabilitation Records
☐ Radiology and/or MRI Images	☐ Outpatient Clinic Reports	☐ Implant Records
☐ Face Sheet – Date(s) of Service:	☐ Visit History	☐ Entire Record (Does not include imaging)
☐ Other:		

☐ This request is for the purpose of supporting an application, claim or appeal for a government benefit or government program.

Delivery Method:
- ☐ Please call me when my information is ready to be picked up.
- ☐ Please email me when my information is ready to be picked up.
- ☐ Please send the copy of my information to me at the above address.
- ☐ Please send the copy of my information to me at the following address (records will **NOT** be emailed):

_____ _____

Signature of Patient or Personal Representative*: Print Name of Patient or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

If you are requesting records on behalf of an adolescent patient (ages 12-17), the adolescent patient must sign below. (NYS Public Health Law §§ 17 and 18)

Signature of Adolescent Patient: _____

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ADDITIONAL INFORMATION

If you requested a copy of your information (not including your Radiology/MRI images), we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is up to $0.75 per page and must generally be paid before or at the time we give the copies to you. You will receive an invoice detailing the costs to copy your records.

If you requested a copy of your radiology/MRI images, we may charge a fee for the cost of preparing and providing those images. The standard fee is up to $35.00 for a CD. An image viewer will be added for viewing on MAC / Apple.

If you requested a summary or explanation of your information, we may charge a fee to re- cover the costs of preparing and providing the requested summary or written explanation. We will contact you with an estimate of any fees before we prepare these items, so that you may decide whether to proceed with your request.

*Personal Representative — An individual authorized by law to act on behalf of a patient. Examples include parents or guardians of unemancipated minors, health care agents, and powers of attorney.

Once you have completed the Request for Access to Health Information form, please return the form to the following address:

Mail: Health Information Management Department
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021

Fax: (212) 774-7364 or (212) 606-1859

If you have questions, please call the HSS Health Information Management Department at (646) 797-8254 during regular business hours (9am – 5pm, Monday – Friday)