University of Rochester Medical Center Strong Memorial Hospital

Department or Practice:	
Address:	
City, State, Zip:	
Phone:	

PATIENT/PERSONAL REPRESENTATIVE REQUEST TO INSPECT AND/OR OBTAIN PHOTOCOPIES OF HEALTH INFORMATION

Request is hereby ma	ide for access to medical [☐ psychiatric information regarding:
Patient's name:		Date of Birth:
Address:		
Patient's daytime pho	one ()	
What type of access	are you requesting?	
☐ Paper Copy	The fee for copies is \$0.75 per page, plus tax and postage. If your request for copies is granted, you should receive notification of cost or the copies within 30 days. $PLEASE\ CHECK\ HERE\ \Box\ IF\ YOU\ NEED\ TO\ PICKUP\ YOUR\ RECORDS.$	
☐ Electronic Copy	The fee for electronic copies (on CD): 1-6 pages FREE, 7-30 pgs \$5, 31-60 pgs \$20, 61-79 pgs \$45, 80+ pgs \$60.	
□VIEW	If your request to view the information is granted, you will be notified within 10 days on how to schedule an appointment with our staff. When viewing, you may request items for copying.	
☐ MyChart		able for 30 days after which time will be removed.
Type of record: Cha	eck all that apply:	
☐ Inpatient: DATES _		Regarding <u>:</u>
☐ Outpatient/Office vi	sits: DATE(S)	Regarding:
What information wo	uld you like to access? Check only	ONE option:
Abstract for the di operative reports, pathol	for the date specified above ate specified above (abstract=dischalogy reports, diagnostics.)	arge summary, history/physical, consults, x-ray reports, labs,
this section.		led to a different person (i.e. Relative/Friend) please complete _ Daytime phone #: ()
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I understand that the fe notified by phone or made not want to pay the	the for copies may be up to \$0.75 per pail as to the cost of copying and I will use fees. If access is denied pursuant and Accountability Act (HIPAA) I	rage. If there are more than 30 pages to be copied, I will be I have an opportunity to modify or withdraw my request if I to New York State Public Health Law or Federal Health Privacy regulations, I will be so notified and provided
Signature of Patient of	or Representative:	Date:
Co-Signature of Mine	or Patient (ages 12-17)*:	

*A minor's signature (ages 12-17) is required for the following records: HIV-related information, sexually related treatment, mental health care, or substance abuse diagnosis and treatment.