University of Rochester Medical Center
Highland 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 made for access to ☐ **medical** ☐ **psychiatric** information regarding:

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Patient's daytime phone ( ) - _____

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 ☐ 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	Upload to MyChart free. Available for 30 days after which time will be removed.

Type of record: *Check all that apply:*

☐ Inpatient: **DATES**_____Regarding:_____

☐ Outpatient/Office visits: **DATE(S)** _____Regarding:_____

What information would you like to access? *Check only **ONE** option:*
☐ Complete records for the date specified above
☐ Abstract for the date specified above *(abstract=discharge summary, history/physical, consults, x-ray reports, labs, operative reports, pathology reports, diagnostics.)*
☐ Other:_____

NOTE: If you want this information ☐ **mailed** and/or ☐ **billed** to a different person (i.e. Relative/Friend) please complete this section.
Name: _____ Daytime phone #: ( )- _____
Address: _____
City/State/Zip Code: _____

I understand that the fee for copies may be up to $0.75 per page. If there are more than 30 pages to be copied, I will be notified by phone or mail as to the cost of copying and I will have an opportunity to modify or withdraw my request if I do not want to pay those fees. If access is denied pursuant to New York State Public Health Law or Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations, I will be so notified and provided information on the appeal process.

Signature of Patient or Representative: _____Date:_____
Relationship to Patient (if requester is not the patient) _____
Co-Signature of Minor 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.**