



Hospital for Special Surgery
Department of Radiology & Imaging Records
 535 East 70th Street (Main Address)
 New York, NY 10021
 212-606-1624 or 212-606-1135
 www.hss.edu

Request for Release of Information

Patient Name: _____

Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Fax #: _____ Phone #: _____

(Please check necessary boxes)

I am requesting a copy of the radiology CD / Films / and/or Reports for my:

Exam type (s) _____,

Exam date (s) _____, to be
 release directly to me or my doctor. *(Attach additional pages with doctor's info).*

According to Section 18 of the NY State Public Health Law, Hospital for Special Surgery is the custodian of all Radiographic Films/Images and therefore must maintain originals. HSS is allowed to impose a reasonable charge for copies provided. The charges are \$12.00 per film or up to \$35.00 for a CD. Ask for JPEG CD if you have an Apple/Mac computer. Please contact HSS Medical Records at 646-797-8254 or 646-797-8255 for all other reports/ notes or access them on your www.hss.edu/myhss online portal.

Please check this box if this request is for an application, claim or appeal for any government benefit or government program.

Signature of Patient or Personal Representative: _____ Date: _____

Print Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

If you are making a request for records on behalf of a child (ages 12-18) – 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: _____

*Please fill out Information above and fax to: **646-714-6060 or 212-774-2327.***

** Copies can also be picked up Monday to Friday from 8am to 6pm at 535 East 70th St., 2 West Room 213.*

Radiology Department use only:

MR # _____

Clerk Initial: _____