HOSPITAL
FOR
SPECIAL
SURGERY

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REQUEST FOR ACCESS TO HEALTH INFORMATION

Our patients have the right to inspect and obtain a copy of most information in our records that may be used to make decisions about them or their treatment for as long as we maintain the information in our records. Please see our Notice of Privacy Practices for a more detailed description of these rights and the process we follow once we have received a request. To request access to records, please complete and return this request form.

PATIENT INFORMATION

Patient Name: _____

Last First MI

Address:

_____

_____

_____

_____

Telephone:

_____ (daytime)

_____ (evening)

Email Address (optional):

_____

Social Security #:

_____

Date of Birth:

_____

If you are requesting a copy, summary, or explanation of the information, how would you like these materials delivered to you? You may pick up these materials at our facility or request that we send them to you by regular mail. If you wish for your records to be sent to another Physician please indicate how it should be sent and include address and fax number below.

Check one: PICK UP: _____ FAX: _____ BY MAIL: _____

_____

_____

_____

SIGNED: _____ PRINT NAME: _____

Patient or Nearest Relative/Relationship WITTNESS: _____