



Request for Access to Health Information

MRN: _____

Patient Name: _____

Name: _____

Address: _____

Date of Birth: _____ Telephone: _____

Email Address (for notification purposes only): _____

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

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

<input type="checkbox"/> Entire Record	<input type="checkbox"/> Face Sheet—Date(s) of Service:	
<input type="checkbox"/> Billing Statements	<input type="checkbox"/> EKG Reports	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Consultations	<input type="checkbox"/> History & Physical Exams	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> HIV/AIDS Test Results	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Radiology and/or MRI Reports	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Rehabilitation Records
<input type="checkbox"/> Radiology and/or MRI Images	<input type="checkbox"/> Outpatient Clinic Records	<input type="checkbox"/> Implant Records
<input type="checkbox"/> HSS Physician Office Records—Physician's Name: _____		
Other: _____		

Applicable dates of treatment: _____

- 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: _____

Hospital for Special Surgery Use Only:

Date received: _____ / _____ / _____

Disposition of request: _____ Granted _____ Denied _____ Partially Denied

Date patient was mailed written notification: _____ / _____ / _____

Fee charged for fulfilling this request (if applicable): \$ _____

Processed by: _____

Request for Access to Health Information

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 \$12.00 per film or up to \$35.00 if you elect to receive an electronic version of your images (CD). ***Please note that our CDs are Windows compatible ONLY and do not run on Apple/Mac computers.***

If you requested a summary or explanation of your information, we may charge a fee to recover 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.

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

****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.

**If you have any questions, please call the
HSS Health Information Management Department at (212) 606-1254
during regular business hours, 8:00 a.m.-5:00 p.m., Monday-Friday.**