HOSPITAL FOR SPECIAL SURGERY

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 Reports)
- ☐ Obtain an **ELECTRONIC** copy of my information. (CD)

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

☐ **Entire Record** (Note: Does not include Billing Statements)	☐ Face Sheet—Date(s) of Service:	
☐ Billing Statements	☐ EKG Reports	☐ Operative Reports
☐ Consultations	☐ History & Physical Exams	☐ Pathology Reports
☐ Discharge Summary	☐ HIV/AIDS Test Results	☐ Progress Notes
☐ Radiology and/or MRI Reports	☐ Laboratory Reports	☐ Rehabilitation Records
☐ Radiology and/or MRI Images	☐ Outpatient Clinic Records	☐ Implant Records
☐ HSS Physician Office Records—Physician's Name:		
Other:		

☐ This request is for the purpose of supporting an application, claim or appeal for a government benefit or government program.

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: _____

If you are requesting records on behalf of an adolescent Patient (ages 12 –18), the adolescent Patient must sign below. (NYS Public Health Law §§ 17 & 18)

Signature of adolescent Patient: _____

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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 or (212) 606-1859

***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 (646) 797-8254 during regular business hours, 8:00 a.m.—5:00 p.m., Monday—Friday.