



**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. Patients may also request that we provide a summary of the information (instead of copies) or an explanation of complicated information. 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: \_\_\_\_\_

## ACCESS REQUESTED

Please answer the following questions. You may attach a separate page if more space is needed.

**What information would you like to access? If you can, please provide the dates that tests were performed or treatment was provided. \***

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*\* Please Note: If you are requesting copies of your radiology films or images contact the Radiology Department at HSS at (212) 606-1134. They will provide you with all the necessary information and answer any questions you may have related to that request.*

**What type of access are you requesting? Check all that apply:**

INSPECT \_\_\_\_\_ COPY \_\_\_\_\_ SUMMARY \_\_\_\_\_ EXPLANATION \_\_\_\_\_

*If your request to inspect the information is granted, we will provide you with further information on how to schedule an appointment with our staff to inspect your records.*

**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 or e-mail.**

Check one: PICK UP \_\_\_\_\_ BY MAIL \_\_\_\_\_ BY E-MAIL \_\_\_\_\_

*Please be sure to complete any applicable mailing address or e-mail address in the Patient Information section of this form.*

**If your request is being made because of an emergency, please describe the nature of the emergency and the date you need the information. We cannot guarantee that we will meet your deadline, but we will do our very best to accommodate reasonable requests.**

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## FEES

**Copying and Distribution Costs.** We will charge you a reasonable fee to recover the costs for copying, mailing, and supplies used to fulfill your request. Our standard fee for is \$ 0.75 per page for patients (or their personal representatives) plus postage and sales tax. You will receive an invoice detailing the costs to copy your record. This invoice must be paid before your record will be mailed or sent to you (or other persons requested by you).

Note: Patients will not be charged a fee for their medical records that are mailed directly to their physicians or caregivers (for continued medical care or treatment).

**Summary or Explanation.** We will also charge a fee to recover the costs of providing any written summary or written explanations (of your record). If a summary or explanation has been requested, 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.

## PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that Hospital for Special Surgery provide me with access to health information in the manner described in this form. I understand that I will be contacted about fees for a: copy, summary, or an explanation, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

**If you have a question, please call the HIM Department during regular office hours between 8:00AM – 5:00PM Monday – Friday (212)-606-1254. The completed form may be faxed to the HIM Department at (212) 606-1859; however, the original must be mailed to the address below (as well).**

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

**SEND COMPLETED FORM  
TO:**

Health Information Management  
Department  
Hospital For Special Surgery  
535 East 70th Street  
New York, NY 10021

**For Hospital for Special Surgery Use Only:**

Date Received: (MO/DY/YR) \_\_\_\_/\_\_\_\_/\_\_\_\_

Disposition of Request: \_\_\_\_ GRANTED \_\_\_\_ DENIED \_\_\_\_ PARTIALLY DENIED

Patient Notified In Writing Of Response To Request On This Date: (MO/DY/YR) \_\_\_\_/\_\_\_\_/\_\_\_\_

Fee Charged For Fulfilling This Request (if applicable): \$ \_\_\_\_\_

Name or Initials of Records Department Staff Member Processing This Request: \_\_\_\_\_