

Instructions For Completing The Request For Access To Health Information By The Patient Or Personal Representative



Below are instructions on properly completing the Request for Access to Health Information by the Patient or Personal Representative Form. An **incomplete or improperly** completed Request for Access Form may delay the delivery of your requested information.

Enter the name, date of birth, address, and telephone number of the **patient requesting records**. There should only be one patient listed on the form.

Patient Name:	Jane Patient	Patient Date of Birth:	09/09/2000
Patient Address:	Patient Telephone #: 321 Main St. Anywhere, NY 516-555-1234		

1. Enter the contact information or health care provider or entity to release this information. If records are needed by more than one person/facility, a separate request *is required*.
 - a. For hospitals or other entities: The name of the hospital or entity must be entered in this area (ex. North Shore University Hospital, or Imaging at Smithtown).
 - b. For Doctor's Office: The name and address of the doctor must be entered. (example: Dr. Jane Jones at 300 Northwell Drive). If only one doctor is listed, then Northwell Health will only release that specific location information.

1. Northwell Health Entity/Facility to Release this Information (From Who):	Doctor Name/Hospital
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2. Select an option and enter the complete name of person/physician/facility/company to receive the information (the destination of the records), along with the address, telephone number/fax/e-mail. If records are needed by more than one person/facility, a separate request *is required*. If the records requested are for yourself, please write your complete name and address.

2. Person or Entity Who Will Receive this Information (To Who):
<input type="checkbox"/> To me <input type="checkbox"/> To Another Person or Entity - Provide Name _____ Doctor Name, or Hospital Name

3. Select the preferred delivery method by checking **ONE** of the choices under delivery manner. The delivery details section is required: If Mail, Electronic Mail or Fax, please include the specific address or phone number. If this information is not included, records will be sent via regular mail.

3. Manner	Form/Format	Delivery Details
<input type="checkbox"/> Regular Mail	<input type="checkbox"/> Paper copy <input type="checkbox"/> Secure USB Flash Drive <input type="checkbox"/> CD	Mailing Address: 1 Hospital Way, Anywhere,
<input type="checkbox"/> Pick up at facility	<input type="checkbox"/> Paper copy <input type="checkbox"/> Secure USB Flash Drive <input type="checkbox"/> CD (where available)	N/A
<input type="checkbox"/> Electronic mail	<input type="checkbox"/> Secure email <input type="checkbox"/> Unsecure email (By checking here, I acknowledge that e-mail sent unencrypted means others may be able to access the information and read it once it is transmitted over the internet.)	Email Address: patientname@email.com
<input type="checkbox"/> Fax	N/A	Fax Number: 516-555-1234
<input type="checkbox"/> Other	Please explain:	

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4. Enter the specific information you are authorizing Northwell Health to release. If selecting a time frame for the records to be released, it can be for a single date of service or a range of dates or years.

- **For a doctor's office**, if you are unsure of the time frame, select Medical Record Abstract and the most recent information will be released. A medical record abstract will consist of the following items over the past 1-2 years (or date range specified): Provider/Clinician Documentation, Procedure Reports, Laboratory, Pathology, and Radiology Reports.
- **For a hospital**, A medical record abstract may consist of pertinent contents from the patient's most recent discharge (or date range specified) such as Doctor/clinician Documentation, Testing Results, Procedure Documentation, and Discharge Documentation. If you are unsure of the time frame, contact the facility where you were treated for further information.

4. Requested Health Information:

- Medical Record Abstract (summary of record)
- Medical Record from (insert date) _____ to (insert date) _____
- Entire Medical Record
- Laboratory results for date of service _____
- Radiology images and reports for date of service _____
- Itemized bill for _____
- Other: Please explain _____

5. Complete this section **ONLY IF** the medical records you are requesting contain substance use disorder treatment information or HIV/AIDS Information. Indicate the purpose of the request such as, Personal Record, Second Opinion, Insurance, Employment, or Doctor's Appointment, At the request of individual or transfer of care. The expiration date, event, or condition upon which the form will expire must be a fixed period of time (e.g., 1 Year, 30 days post discharge,).

5. Please complete this section ONLY IF the information you are requesting to access contains substance use disorder treatment information¹ or HIV/AIDS Information:

Purpose of request: _____

Expiration date: _____

If the information contains substance use disorder treatment information please note the following:

- This consent is subject to revocation at any time except to the extent that the Part 2 program that is permitted to make the disclosure has already acted in reliance on it.
- The information may include diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summary, employment information, living situation and social supports, and claims/encounter data.

6. The patient or patient representative completing this form must sign Patient/Agent/Relative/Guardian and include the date and time the form is signed. Print your name if other than the patient. If an interpreter assists with completing this form, his or her information is to be included below. If there is a witness involved with interpretation, his or her information is also to be included.

<i>Patient/Agent/Guardian Signature</i>		Patient Printed First and Last Name		
Patient/Agent/Relative/Guardian* (Signature)		Date	Time	Print Name
Telephonic Interpreter ID, if applicable				
Telephonic Interpreter's ID # OR		Date	Time	Relationship if other than patient
Signature of onsite Interpreter, if applicable		Printed Name of onsite Interpreter, if applicable		
Signature: Interpreter		Date	Time	Print: Interpreter's Name and Relationship to Patient
Signature of Witness, if applicable		Printed Name of Witness, if applicable		
Witness to Signature (Signature)		Date	Time	Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.
¹ Units or programs licensed by OASAS only include programs whose specific purpose is to treat substance abuse disorders.