

REQUEST FOR ACCESS TO HEALTH INFORMATION BY PATIENT OR PERSONAL REPRESENTATIVE

I or my Personal Representative hereby request that Northwell Health provide access to my health information as described in this form. I am making this request under the provisions of the Health Insurance Portability and Accountability Act ("HIPAA") that entitle me to access my own health information including directing it to another person or entity (45 CFR 164.524).

Patient Name: _____ **Patient Date of Birth:** _____

Patient Address: _____ **Patient Telephone #:** _____

1. Northwell Health Entity/Facility to Release this Information (From Who): _____

2. Person or Entity Who Will Receive this Information (To Who):

To me To Another Person or Entity - Provide Name _____

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: _____
<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: _____
<input type="checkbox"/> Fax	N/A	Fax Number: _____
<input type="checkbox"/> Other	Please explain: _____	

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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. 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.

Patient/Agent/Relative/Guardian* (Signature) _____ Date _____ Time _____ Print Name _____ Relationship if other than patient _____

Telephonic Interpreter's ID # _____ Date _____ Time _____
OR

Signature: Interpreter _____ Date _____ Time _____ Print: Interpreter's Name and Relationship to Patient _____

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.