MEDICAL RECORDS REQUEST FORM

Individual's Name:	Last First Middle
Home Address:	
Home Telephone:	**Date of Birth:**

I hereby request that the Practice provide me with **[please check all boxes that apply]**

☐ a copy of the "Requested Information" checked below:
☐ My medical records.
☐ Any other personally identifiable information used by the Practice to make medical decisions about me.

Please check one of the following boxes:

☐ I am only interested in accessing or obtaining a copy of Requested Information relating to the time period _____ through _____.
☐ I am interested in accessing or obtaining a copy of all Requested Information maintained by the Practice.

I understand that any information provided to me pursuant to this request will not include (i) information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be required by applicable law, or (ii) if I am a parent or legal guardian requesting access to a minor's information, records related to certain categories of treatment as required by law (for example, a minor's treatment for venereal disease, the performance of an abortion operation, or care and treatment to which the minor is permitted to consent--without needing to obtain his/her parent's/guardian's consent first--and has so consented, for example, HIV testing, STD diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning services).

I understand that the Practice may deny this request under limited circumstances permitted by federal regulations governing the protection of personally identifiable health information. I further understand that, except as otherwise permitted under applicable federal law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the Practice who did not participate in the Practice's decision to deny my request. If my request is denied again, I understand that I have the right to have such denial reviewed by a medical record access review committee appointed by the Commissioner of the Department of Health of the State of New York.

I understand that the Practice will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request if the information is maintained or accessible on-site at the Practice or within sixty (60) days if the Requested Information is not maintained or accessible on-