Patient Request for Health Information Form

Upstate University Medicine recognizes a patient's right of access under HIPAA. There may be charges associated with processing a request and producing requested records.

Patient Information (Please Print)

First Name:		Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):				
Date of Birth (MM/DD/YYYY):	Phone:		E-mail (optional):	
Street Address:	City:		State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service:_____/____/____through_____/____/_____

☐ Office Notes ☐ Operative/Procedure Reports ☐ Billing Records ☐ Test Results ☐ Please specify: __________

☐ Other Please specify:____

How would you like your records delivered?

☐ Paper Mail ☐ In-Person Pickup ☐ MyChart patient portal ☐ Electronic (Email, USB, CD, Portal)

Other Please specify: ____

Where do you want the information sent? (Fill in boxes below):

Upstate University Medical should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship to Patient (please print)**
Signature of Patient or Personal Representative	**Date/Time**

For internal use by only:

Patient Identification #:	*Date Received:*	*Date Processed:*	*Processed By:*
Fee Charged:	*Were Records Reviewed On-site?*	*Date Reviewed:*	