UNIVERSITY PHYSICIANS
BROOKLYN, INC.

REQUEST FOR PATIENT INFORMATION FORM

Patient Name: _____
Last First MI

Address: _____

_____

DOB: _____

1. Persons/ Practice requesting the information: _____

2. Information requested from:

   Name: _____

   Address: _____

   _____

   Telephone #: _____

3. Information to be disclosed:
   Period(s) of treatment from: _____ /_____ /_____ to _____ /_____ /_____

   __ Complete Medical Record
   __ Partial Medical Record; specify _____

   _____

   _____

4. Is information regarding mental health, any HIV- related condition (including HIV-related test, illness, AIDS or any information indicating potential exposure to HIV) or drug and alcohol abuse being requested?

   __ Yes (Attach special authorization form)

   __ No

5. This information is being requested for the following purpose:

   __ Pursuant to the patient's authorization (Attach Patient Authorization form)

   __ For a purpose that does not require patient authorization; specify below:

      __ Treatment purposes

      __ Payment purposes

      __ Required by law

      __ Public health activities

__ Health oversight activities

__ Judicial and administrative proceedings

__ Avoiding serious threat to health or safety

__ Specialized government functions

__ Worker's compensation

__ Other; specify _____

6. Date Information is Needed: _____

As a covered entity under HIPAA, University Physicians of Brooklyn, Inc. (UPB) is aware that this information may not be re-disclosed, unless permitted to do so under state or federal law. UPB certifies that any patient authorizations attached are valid, to the best of its knowledge, and that the information requested is the minimum amount necessary to accomplish the specified purpose.

_____ _____

Print Name Of UPB Staff Member Date

_____ _____

Practice Telephone Number