SUNY DOWNSTATE Medical Center

REQUEST FOR PATIENT INFORMATION FORM

Patient Name: _____
Last First MI

Address: _____

_____

DOB: _____

1. Persons/ Organizations requesting the information:
__ University Hospital of Brooklyn- Main; specify department: _____
__ University Hospital of Brooklyn- Lefferts
__ University Hospital of Brooklyn- Midwood
__ University Hospital of Brooklyn- Dialysis Center
__ SUNY Downstate Medical Center at Bay Ridge
__ University Physicians of Brooklyn, Inc. (UPB); specify practice plan _____
__ Research Foundation
__ Student/ Employee Health
__ Other; specify _____

2. Information requested from:

Name: _____

Address: _____

_____

Telephone #: _____

3. Information to be disclosed:
Period(s) of hospitalization or treatment from: _____ /_____ /_____ to _____ /_____ /_____
[ ] In-patient Hospitalization [ ] Outpatient Treatment [ ] Ambulatory Surgery [ ] ER

__ Complete Medical Record
__ Discharge Summary
__ History & Physical Examination
__ Progress Notes
__ Consultation Reports
__ Operative Reports
__ Radiology Reports
__ Laboratory Tests
__ Clinic Visit; specify clinic name _____
__ Other; 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, SUNY Downstate Medical Center is aware that this information may be not be re-disclosed, unless permitted to do so under state or federal law. SUNY Downstate Medical Center 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 SUNY Downstate Staff Member Date

_____ _____

Department Telephone Number