



REQUEST FOR ACCESS- FEE ESTIMATE

[Date]

[Patient Name]

[Street Address 1]

[Street Address 2]

[City, State Zip Code]

Re: Request For Access to Health Information

Dear [Patient Name]:

This letter responds to your request to access your health information, which we received from you on _____.

We have determined that the following fees will apply if we process your request:

- ☐ A fee of \$ _____ per hour will be charged to prepare a summary of the information for you. We estimate that the preparation will take ____ hour(s).
- ☐ A fee of \$ _____ will be charged to prepare an explanation of the information for you. We estimate that the preparation will take ____ hour(s).

We want you to know that you have the following options. Please check the appropriate box and return within 60 days to SUNY Downstate Medical Center University Hospital of Brooklyn, _____ Department- Box #_____, 450 Clarkson Ave., Brooklyn, NY 11203.

- ☐ Proceed with my request. I have enclosed the fee provided in this letter.
- ☐ Withdraw my request. I will pay no fee.
- ☐ Modify my request to reduce the applicable fee. Specify modification of request:

If we do not hear from you within 60 days, we will assume that you have decided to withdraw your request.

_____ Department