UNIVERSITY PHYSICIANS
BROOKLYN, INC.

PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

As our patient, you have the right to inspect and obtain a copy of most information in our records that may be used to make decisions about you or your treatment for as long as we maintain that information. You may also request a summary of the information, instead of copies, or an explanation of complicated information.

Patient Name: _____
Last Name First Name MI

Address: _____ Telephone:

_____ _____ (daytime)

_____ _____ (evening)

What information would you like to access?

__ Entire medical record

__ Specific visit; Specify date _____

__ Specific tests/ reports; Specify tests/ reports and date _____

__ Other information; Specify _____

_____

What type of access are you requesting?

__ Inspection: We will provide you with further information on scheduling an appointment with our staff.

__ Copy: __ Pick up or __ Send by mail

__ Summary: __ Pick up or __ Send by mail

__ Explanation: __ Pick up or __ Send by mail

If your request is being made because of an emergency, please state the date you need the information. We will do our best to accommodate your request: _____

FEES

Copying, Mammogram and Distribution Costs: We will charge you a reasonable fee to recover the costs of copying, mailing and supplies used to fulfill your request. Our standard fee for copying is $0.75 per page. Original mammograms generally cost about $____. We will not contact you before this information is prepared.

Summary or Explanation: We will also charge a fee to recover the costs of providing any summary or explanation you have requested. We will contact you with an estimate of the fee before we prepare these items. You can then decide whether you want to continue with the request, modify the request to reduce the fee or withdraw your request and pay no fee.

By signing below, I certify that I am requesting access to my health information in the manner described above. I understand that I will only be contacted for fees for any summary or explanation.

_____ _____
Print Name of Patient/ Personal Representative Signature of Patient/ Personal Representative

_____ _____
Description of Personal Representative's Authority Date

FOR UPB USE ONLY- To be completed by appropriate staff member:

Date Request Received: (MM/DD/YY) ___/___/___

Disposition of Request:

__ Granted

__ Denied

__ Partially Denied

Date Patient Notified of Response: (MM/DD/YY) ___/___/___

If request has been partially denied, what information is the patient permitted to access?

_____

_____

_____

Date of Patient Inspection: (MM/DD/YY) ___/___/___ __ Not applicable

Date Copies Provided: (MM/DD/YY) ___/___/___ __ Not applicable

Fee for Copies: $_____ __ Not applicable

Fee for Summary/ Explanation: $_____ __ Not applicable

_____ _____

Name of UPB Staff Member Date

REMINDER: APPEND COPIES OF SUMMARY/ EXPLANATION TO PATIENT'S MEDICAL RECORD.