UNIVERSITY of ROCHESTER MEDICAL CENTER
& Affiliates

Facility: Thompson Health
Department Name: HIM
Address: 350 Parrish Street
Canandaigua, NY 14424
Phone #: 585/919-3849
Fax #: 585/396-6719

# PATIENT/PERSONAL REPRESENTATIVE REQUEST TO INSPECT AND/OR OBTAIN PHOTOCOPIES OF HEALTH INFORMATION

Request is hereby made for access to ☐ **medical** ☐ **mental health** information regarding:

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Patient's daytime phone ( ) - _____

**What type of access are you requesting?**

| | |
|---|---|
| ☐ View | You will be notified within 10 days on how to schedule an appointment with our staff. When viewing, you may request items for copying. |
| ☐ Electronic Copy | You should receive notification within 30 days of cost of the copies you have requested. |
| ☐ Paper Copy | You should receive notification within 30 days of cost of the copies you have requested. |

***PLEASE CHECK HERE*** ☐ ***IF YOU NEED TO PICKUP YOUR RECORDS***.

**Type of record:** *Check all that apply:*

☐ Inpatient: **DATES**_____Regarding:_____

☐ Outpatient/Office visits: **DATE(S)** _____Regarding:_____

**What information would you like to access?** *Check only **ONE** option:*

☐ Complete records for the date specified above

☐ Abstract for the date specified above *(abstract=discharge summary, history/physical, consults, x-ray reports, labs, operative reports, pathology reports, diagnostics.)*
☐ Radiology ☐ CD ☐ Reports for DATES: _____

☐ Other:_____

**NOTE:** If you want this information ☐ **mailed** and/or ☐ **billed** to a different person (i.e. Relative/Friend) please complete this section.

Name: _____ Daytime phone #: ( ) - _____
Address: _____
City/State/Zip Code: _____

If access to my medical record is denied pursuant to New York State Public Health Law or Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations, I will be notified and provided information on the appeal process.

Signature of Patient or Representative: _____Date:_____
Relationship to Patient (if requester is not the patient) _____
Co-Signature of Minor Patient (ages 12-17)*****: _____

***A minor's signature (ages 12-17) is required for the following records: HIV-related information, sexually related treatment, mental health care, or substance abuse diagnosis and treatment.**