MEDICAL RECORDS REQUEST FORM

Individual's Name:	Last First Middle
Home Address:	
Home Telephone:	**Date of Birth:**

I hereby request that the Practice provide me with **[please check all boxes that apply]**

☐ a copy of the "Requested Information" checked below:
☐ My medical records.
☐ Any other personally identifiable information used by the Practice to make medical decisions about me.

Please check one of the following boxes:

☐ I am only interested in accessing or obtaining a copy of Requested Information relating to the time period _____ through _____.
☐ I am interested in accessing or obtaining a copy of all Requested Information maintained by the Practice.

I understand that any information provided to me pursuant to this request will not include (i) information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be required by applicable law, or (ii) if I am a parent or legal guardian requesting access to a minor's information, records related to certain categories of treatment as required by law (for example, a minor's treatment for venereal disease, the performance of an abortion operation, or care and treatment to which the minor is permitted to consent--without needing to obtain his/her parent's/guardian's consent first--and has so consented, for example, HIV testing, STD diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning services).

I understand that the Practice may deny this request under limited circumstances permitted by federal regulations governing the protection of personally identifiable health information. I further understand that, except as otherwise permitted under applicable federal law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the Practice who did not participate in the Practice's decision to deny my request. If my request is denied again, I understand that I have the right to have such denial reviewed by a medical record access review committee appointed by the Commissioner of the Department of Health of the State of New York.

I understand that the Practice will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request if the information is maintained or accessible on-site at the Practice or within sixty (60) days if the Requested Information is not maintained or accessible on-

site at the Practice. If the Practice is unable to comply with my approved request within the applicable time limit, it may extend the applicable deadline for up to thirty (30) days by notifying me in writing.

I would prefer to: ☐ pick-up or view the Requested Information at a mutually agreeable time and place; ☐ have a copy of the Requested Information mailed to me at the following address:

_____
_____
_____

I understand that the Practice will charge me **[$0.75]** per page for copying fees and that there may be an additional fee for clerical work necessary to complete my request, as well as any applicable mailing fees. If I am granted access to the Requested Information, I **[please check the appropriate boxes]**
☐ would ☐ would not like the Practice to provide me with an additional written ☐ summary ☐ explanation of such Requested Information at an additional cost to me of **[**$_____**]**.

_____ _____
Signature of Patient (or Personal Representative) Date

_____ _____
Printed name of Personal Representative Relationship to Patient

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After you have completed this form please return it to our office:
Murray Hill Medical Group, P.C.
317 East 34th Street
ATTN: "The name of your specific Doctor"
New York, NY 10016

You may also fax it directly to your physicians office.