Request for HIPAA information

To be completed by patients

orthoNY

Date

Patient information

Name

Date of birth

Address

City State Zip

OrthoNY physician name

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information.

I understand that the charge for this service is $.75 per page. $5 per CD for images I also understand OrthoNY has up to 10 days to respond to this request.

Patient's signature Date

Print name of patient or legal guardian

Will you be picking the records up: **Yes** **No**

If no, address where the records should be sent:

Name of Practice:_____

Street Address:_____

City:_____ State:_____ Zip code:_____

Attention:_____

X-rays/MRIs needed: **Yes** **No**

FOR INTERNAL USE ONLY

Date request received

Number of pages copied Total cost