Request for HIPAA information

To be completed by patients

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.

There is a $5 per CD charge 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