Peconic Bay Medical Center
Northwell Health®

REQUEST FOR ACCESS TO HEALTH INFORMATION BY PATIENT OR PERSONAL REPRESENTATIVE

I or my Personal Representative hereby request that Northwell Health provide access to my health information as described in this form. I am making this request under the provisions of the Health Insurance Portability and Accountability Act "HIPAA") that entitle me to access my own health information including directing it to another person or entity (45 CFR 164.524).

Patient Name: _____ **Patient Date of Birth:** _____

Patient Address: **Patient Telephone #:**

_____ _____

_____

1. Northwell Health Entity/Facility to Release this Information (From Who): _____

2. Person or Entity Who Will Receive this Information (To Who):

☐ To me ☐ To Another Person or Entity - Provide Name _____

3.

Manner	**Form/Format**	**Delivery Details**
☐ Regular Mail	☐ Paper copy ☐ Secure USB Flash Drive ☐ CD	Mailing Address:
☐ Pick up at facility	☐ Paper copy ☐ Secure USB Flash Drive ☐ CD (where available)	N/A
☐ Electronic mail	☐ Secure email ☐ Unsecure email (By checking here, I acknowledge that e-mail sent unencrypted means others may be able to access the information and read it once it is transmitted over the internet.)	Email Address:
☐ Fax	N/A	Fax Number:
☐ Other	Please explain:	

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4. Requested Health Information:

☐ Medical Record Abstract (summary of record)

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record

☐ Laboratory results for date of service _____

☐ Radiology images and reports for date of service _____

☐ Itemized bill for _____

☐ Other: Please explain _____

5.

Please complete this section ONLY IF the information you are requesting to access contains substance use disorder treatment information[1] or HIV/AIDS Information:

Purpose of request: _____

Expiration date: _____

If the information contains substance use disorder treatment information please note the following:

- This consent is subject to revocation at any time except to the extent that the Part 2 program that is permitted to make the disclosure has already acted in reliance on it.
- The information may include diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summary, employment information, living situation and social supports, and claims/encounter data.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date	Time		
OR				
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to Signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

[1] Units or programs licensed by OASAS only include programs whose specific purpose is to treat substance abuse disorders.

VD087 (9/28/21)