NYU Langone MEDICAL CENTER

Patient Request to Inspect Protected Health Information

Federal and state law provide you the right to inspect medical records, billing records or other records that we may use to make health care decisions about you, for as long as the information is maintained in a Designated Record Set. You may also request that we provide a summary or an explanation of the information in lieu of access to inspect the information. Please see our Notice of Privacy Practices for a more detailed description of these rights and the process we follow once we have received your request. To make a request to inspect your health information, please complete and return the form to the appropriate department listed below. You will receive a response within 10 days of receipt of your request.

- For access to inspect Tisch Hospital records, Rusk Rehabilitation Institute records, and other NYU Hospitals Center site records, return to: Health Information Management, NYU Hospitals Center.
- For access to inspect Hospital for Joint Disease records return to: Health Information Management, Hospital for Joint Diseases.
- For access to inspect Cancer Center records return to: Health Information Management, NYU Clinical Cancer Center.
- For access to inspect School of Medicine/Faculty Group Practice records send to the individual physician's office.
- For access to inspect your billing records, return to: Customer Service, Revenue Cycle for NYU Hospitals Center billing records and Central Billing Office for Faculty Group Practice billing records.

Patient Name (print): _____

Patient Address: _____
Phone Number: _____ Email: _____

Description of information you are requesting access to inspect (list specific dates of service):
_____
_____

☐ I am requesting an opportunity to INSPECT the above information. -OR-

☐ I am requesting that the Medical Center provide a SUMMARY OR EXPLANATION of the above information in lieu of my right to inspect the information. I understand that I will be charged a reasonable, cost-based fee not to exceed $50 for the preparation of the summary or explanation.

By signing below, I am requesting that NYU Langone Medical Center permit access to the above described Protected Health Information. I agree to all charges associated with my request.

Signature: _____ Date: _____ Time: _____ AM/PM
(Patient or person authorized to sign)
If the consenting party is other than the patient, print name and relation to patient:
_____

Office Use: Received: ____/_____/_____ Completed: ____/_____/_____ Initials: _____

(Rev. 11/13)