

## Request for Access to Health Information

As a patient of a Columbia University Health Sciences Provides, you may access certain health information we maintain for you. If you want to inspect and/or receive a copy of your health information, you must complete this form and **return it to the health care provider office** from which you are requesting access to your health information or you may submit it to the Privacy Officer at: Columbia University Health Sciences, 601 West 168<sup>th</sup> Street, Apt. 22, New York, NY 10021. This request applies only to the health care provider office you indicated below. If you would like to receive information from more than one health care provider office, you must complete a separate form for each office.

To assist us in locating your information, please provide the following:

Last Name:

First Name:

Date of Birth: M   D   Y

Telephone:    -    -

Mailing Address: \_\_\_\_\_

Please specify the health care provider office from which you are requesting access to your health information:  
Center for Women's Reproductive Care at Columbia University

Please indicate, by checking the appropriate box(es), the specific information to which you want access:

Medical records for the following dates: \_\_\_\_\_

Billing records for the following dates: \_\_\_\_\_

Other, Please specify: \_\_\_\_\_

Please indicate whether you would like to inspect or receive a copy of your health information by checking the applicable box(es):

I would like a copy of my health information

I would like a copy of my health information sent to the following provider at the address indicated below:  
\_\_\_\_\_  
\_\_\_\_\_

I would like to inspect my health information in person at the Columbia University Medical Center.

We charge fees for copies and postage, as permitted by applicable state and federal law. You will be informed of the total due before your copies are provided to you.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If personal representative, authority to act on behalf of patient

***For Office Use Only:***

Date Received: \_\_\_\_\_

Staff Completing Request (print): \_\_\_\_\_ Date Completed: \_\_\_\_\_

Staff Completing Request (Signature): \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_