



Attention Health Information Management (HIM)  
5496 East Taft Road, North Syracuse, NY 13212

**PATIENT REQUEST TO OBTAIN A COPY OF HIS/HER MEDICAL RECORDS**

Failure to complete this form in its entirety will result in a delay in you receiving your records.

**We will not take corrections over the phone.**

**1. Patient Information (Please Print)**

\_\_\_\_\_  
Last                      First    Middle                      Date of Birth                      Contact Phone Number

\_\_\_\_\_  
Address:              Street Address                      City                      State                      Zip Code

I am requesting New York Spine and Wellness Center to provide me with a copy of my medical records. I understand that these records contain protected health information (PHI). NO FEE IS CHARGED . You will receive a phone call when the records are ready.

**2. I prefer my records to be; choose one**

- Paper format                       CD(s) in PDF format

**3. Select the records you are requesting:**

- All Records               Lab results (including drug screens)               Office notes               Procedure notes  
 Diagnostic reports (MRI, CT etc.)               Other \_\_\_\_\_

**4. Specify date range** \_\_\_\_\_ to \_\_\_\_\_

**5. Please check one:**

\_\_\_ I prefer they be mailed to me at the address above.

\_\_\_ Please have my records available. I will pick them up at the office I selected:  Taft Road     Glacier     Camillus

\_\_\_ I designate \_\_\_\_\_ to pick up my records for me at     Taft Road     Glacier     Camillus

\* The name of the person you designate *must match the photo ID* they present at time of pick up.

\_\_\_\_\_  
Signature of Individual                      Date of request

If this Authorization is to be signed by a Personal Representative of the Individual, please complete the following:

\_\_\_\_\_  
Signature of Personal Representative                      Printed Name of Personal Representative

Description of authority: \_\_\_\_\_  
(A personal representative must provide legal proof of representation, e.g., guardian, health care proxy, power of attorney)

We will respond to requests for copies within 30 days if the information is located within our facility and within 60 days if the information is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request

*For office use only*

\_\_\_\_\_  
Signature of Staff Fulfilling the request                      Signature of staff verifying records                      Date Request Completed