Attention Medical Records
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). I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable). I agree to pay for this prior to the service being rendered. You will receive a phone call with the amount owed.

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

☐ Paper format, I agree to pay $5.00 for records exceeding 25 pages ☐ CD(s) in PDF format/ $5 per CD

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 ☐ Widewaters ☐ Camillus

____I designate _________________________ to pick up my records for me at ☐ Taft Road ☐ Widewaters ☐ 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