VNS Health

PATIENT ACCESS REQUEST FORM

VNS Health
Attn: Medical Records Department
220 East 42nd Street, 6th Floor
New York, NY 10017
Email: Records.Requests@vnshealth.org
Fax: 1 (646) 640-2882

Please Note: Reasonable cost-based fees MAY apply

Patient Name: _____
Address: _____
City, State, Zip: _____
Date of Birth: _____
Patient Phone Number: _____
Medical Record #: (if known) _____

I am requesting a copy of my Protected Health Information (PHI) in the VNS Health Designated Record Set pursuant to the HIPAA Right of Access regulations at 45 C.F.R. § 164.524(a)(1). I am requesting records from the following VNS Health entities:

☐ All VNS Health Entities ☐ VNS Health Home Care ☐ VNS Health Hospice Care

☐ VNS Health Personal Care ☐ Medical Care at Home, P.C.

☐ VNS Health Health Plans ☐ Other: _____

_____

SPECIFIC PHI TO RELEASE - (Check box of items to be released)

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

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to VNS Health by other health care providers

☐ Other: _____

_____

_____

Include: *(Indicate by Initialing)*

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

I understand that if I have not initialed above to request disclosure of alcohol/drug treatment information, mental health information, or HIV-related information, VNS Health will not disclose such information in response to this request. I understand that any HIV-Related Information disclosed to another person consistent with my request as indicated by my initials above and selection of Recipients below is disclosed from confidential records which are protected by New York State law. State law prohibits such Recipient from making any further disclosure of this information without my specific written consent, or as otherwise permitted by law. Any unauthorized further disclosure in violation of New York State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not, except in limited circumstances, sufficient authorization for further disclosure. Disclosure of confidential HIV-Related information that occurs as the result of a general authorization for the release of medical or other information will be in violation of the State law and may result in a fine or a jail sentence or both.

Recipient:
☐ Myself
☐ Parent or Legal Guardian
☐ Legal Representative

Recipient Address:
Name: _____
_____
Phone: _____
Fax: _____
Email: _____

Format:
☐ Email (you will receive a link and instructions to download a PDF)
☐ Flash drive (secure pdf format)
☐ Paper copies sent by mail
☐ Paper copies sent by fax
☐ Paper copies to be picked up from VNS Health at the address above
☐ Inspection of PHI at VNS Health (we will contact you to schedule)
☐ Other (please specify): _____

Issued Date: 10/13/2022; Last Updated: 10/13/2022

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IMPORTANT INFORMATION: I understand that if I ask VNS Health to disclose PHI to another individual or entity, that information may no longer be protected by New York and Federal privacy laws, including HIPAA. I understand that VNS Health will make reasonable attempts to produce the documents in the format requested; however, if the records are not readily reproducible in that format, I understand VNS Health will call to discuss alternative delivery options. I understand that VNS Health may charge reasonable, cost-based fees for delivery of PHI in certain formats. In certain limited circumstances, VNS Health may deny a request. If a request is denied, I understand I will be given a written explanation and a description of steps I may take in response to the denial.

SIGNATURES

Date/Time:_____ **Patient Signature**:_____

If patient is unable to sign authorization form because of age or physical or mental condition, complete the following:

☐Patient is a minor

☐Patient is unable to sign authorization because:_____

Date/Time:_____ **Signature**: _____

Description of personal representative's authority to act for the patient: _____

_____

<u>How to submit this form</u>: Please submit your completed <u>Patient Access Request Form</u>, and copies of any supporting documentation, to the VNS Health Medical Records Department by mail, email, or fax. The VNS Health Medical Records Department's contact information is located at the top of this form.

<u>FOR VNS HEALTH USE ONLY</u>

Date Request Received:	Date VNS Health Responded to Request:
VNS Health Representative Name/Signature:	Date:

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