

## **Request for a Copy of Your Medical Record**

As a patient of Columbia University Medical Center, you may request a copy of certain health information we maintain about you. If you want a copy you must complete this form and return it to the health care provider office at Columbia University Medical Center from which you are requesting your records. You may also inspect in person your medical records maintained by that office by submitting this form. This request only applies to the health care provider's office you indicate 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:

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

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

Please indicate provider's name and office from which you are requesting a copy of your health information.

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 Health Sciences.

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 Columbia University Health Sciences purposes only:**

Date of receipt of request: \_\_\_\_\_.

Referred for further information?  Yes  No

Time extension required?  Yes  No

Decision:  access granted in full.  access denied in full  access granted in part  summary or explanation

Date of notification of decision: \_\_\_\_\_.  
No

Review of denial requested?  Yes  No

Review of denial assigned to: \_\_\_\_\_.

Review of denial decision:  unreviewable  concur with original decision  disagree with original decision

Date of notification of decision on review of denial: \_\_\_\_\_.