MEDICAL RECORD COPY FEES FOR PERSONAL USE ONLY
Pages 1-10 : Courtesy/no charge
Pages 11-26: .75 per page
Pages 27 and up: Flat rate of $20

Patient REQUEST for Health Information Form

(Form to be used when PATIENT requests copies of their Medical Record)

UPSTATE ORTHOPEDICS recognizes a patient's right of access under HIPAA. There may be charges associated with processing a request and producing requested records.

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service:_____/____/____through______/_____/______ Provider(s):____________________

☐ Office Notes ☐ Discharge Summaries ☐ Operative/Procedure Reports ☐ Billing Records

☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: ____________________

☐ Other (Immunization Records, Medication Lists) Please specify: ____________________

How would you like your records delivered?

☐ MyChart patient portal

☐ Paper ☐ In-Person Pick Up ☐ Mail Delivery

☐ CD

Where do you want the information sent? (Fill in boxes below):

UPSTATE ORTHOPEDICS should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship to Patient (please print)**
Signature of Patient or Personal Representative	**Date/Time**

Please return completed form to:

UPSTATE ORTHOPEDICS
6620 Fly Road, Suite 200
East Syracuse, NY 13057
Phone: (315)-464-4472
Fax: (315-464-1594

For internal use by *Upstate Orthopedics* only:

Patient Identification #:	*Date Received:*	*Date Processed:*	*Processed By:*
Fee Charged:	*Were Records Reviewed On-site?*	*Date Reviewed:*	