Yale University Form

Request Access to PHI Retained in the Designated Record Set

PATIENT NAME:_____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH:_____-_____-_____ PHONE NUMBER:_____
MO DAY YR

ADDRESS:_____

CITY:_____STATE:____ZIP:_____

EMAIL ADDRESS (If applicable):_____DATE:_____

INFORMATION TO BE RELEASED:
Note our patient portal MyChart is an easy way to accessand print much of your record at any time. Please consider using the portal to obtain your records.

- ❑ All Records
- ❑ Discharge Summary
- ❑ Medication Records
- ❑ Other Procedure Report
- ❑ Immunization Records
- ❑ Images/Videos/Records
- ❑ History & Physical
- ❑ Progress Notes
- ❑ Radiology Reports
- ❑ Other (Please describe): _____
- ❑ Pathology Reports
- ❑ Lab Reports
- ❑ Operative Report/Notes
- ❑ Itemized Billing Statement

DATES OF SERVICE:_____

FORMAT: ❑ Inspection ❑ Paper Copy ❑ Electronic Copy
Note email is not a secure means of communication. If you are willing to accept that risk, we will send your records via email upon request. Please note your email address above. Otherwise, you may pick up the records or records will be sent via US mail to the address provided.

INFORMATION TO BE RELEASED TO: ❑ Self
❑ Other (Please specify): _____
_____
_____
_____

I understand that I will receive a copy of this Form and that my request will be processed within thirty (30)days. I understand if I checked the "Inspection" box above that I will need to schedule an appointment with my healthcare provider to review ONLY the information specified to be released.

I understand if I checked the "Copy" box above that I will be responsible for paying a reasonable cost-based fee for supplies, labor, postage and copying in accordance with HIPAA and that the requested information will be mailed to me via US postal mail at the address indicate above. See fee schedule at http://hipaa.yale.edu/sites/default/files/files/5002-EX-5002B.pdf.

I understand that this request for release of information may be denied or reduced and only portions released. If so, I have the right to request a review of this decision by another licensed health care professional that Yale designates by submitting my request in writing to the Privacy Office as listed below.

I have the right to file a written complaint concerning any final denial of my request for access within 180 days of my receipt of this denial to: Privacy Officer, Yale University, P.O. Box 208255, New Haven, CT 06520-8255

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____
RELATIONSHIP TO PATIENT

Date records released:_____

Revised: August. 2019