

PATIENT REQUEST FOR HEALTH INFORMATION

DATED: _____

Patient Name: _____

Date Of Birth : _____

Telephone: _____

Social Security Number: _____

Please provide access to the above patient for the following Patient Health Information.

MEDICAL RECORDS

FILMS

OTHER: _____

DESCRIPTION OF INFORMATION:

Check this box if patient personally picking up (PHI)

Check this box if patient personally delivering (PHI) to Primary Care Physician

Primary Care Physician: _____

Telephone: _____ **Date (PHI) Released:** _____

I understand that the practice can reasonable charge me for Film\$ _____
or copying _____ cents per copy.

PATIENT SIGNATURE

PRINT NAME

DATE: _____

PLEASE MAIL TO:

**LONG ISLAND RADIOLOGY ASSOC.P.C.
ATT: Privacy Officer
1575 Hillside Ave. New Hyde Park NY 11040**