GOLDMAN DERMATOLOGY, PLLC
150 Broadway, Suite 1110
New York, NY 10038
212-962-1115

ACCESS REQUEST FORM

Individual's Name: _____
Last First Middle

Home Address: _____
_____

Home Phone: _____ Date of Birth: _____

I hereby request that the Practice provide me with (please check all that apply) access to a copy of the "Requested Information" checked below:

- ☐ My medical records.
- ☐ My lab/biopsy results
- ☐ My billing records
- ☐ Any other personally identifiable information used by the Practice to make medical decisions about me.

Please check one of the following:

- ☐ I am only interested in accessing or obtaining a copy of Requested information relating to the time period _____through _____.
- ☐ I am interested in accessing or obtaining a copy of all Requested information maintained by the Practice.
- ☐ I would prefer to receive the Requested Information in the form of a summary prepared at a cost to me of $ 0.00.

I understand that any information provided to me pursuant to this request will not include (1) information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be required by applicable law, or (2) if I am a parent or legal guardian requesting access to a minor's information, records related to certain categories of treatment as required by law (for example, a minor's treatment for venereal disease, the performance of an abortion operation, or care and treatment to which the minor is permitted to consent – without needing to obtain his/her parent's/guardian's consent first – and has so consented, for example, HIV testing, STD diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning).

I understand that the Practice may deny this request under limited circumstances permitted by federal regulations governing the protection of personally identifiable health information. I further understand that, except as otherwise permitted under applicable federal law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the Practice's decision to deny my request. If my request is denied again, I understand that I have the right to have such denial reviewed by a medical record access review committee appointed by the Commissioner of the Department of Health of the State of New York.

I understand that the Practice will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request information is maintained or accessible on-site at the Practice. If the Practice is unable to comply within the applicable deadline for up to thirty days by notifying me in writing.

Please provide the Requested Information to me in [please check the appropriate line] __pick-up at the office or __have a copy of the Requested Information mailed to me at the following address:

_____
_____
_____

I understand that the Practice can charge me [$0.00] per page for copying fees and [$0.00] per hour of clerical work necessary to complete my request, as well as applicable mailing fees. If I am granted access to the requested information, I [please check the appropriate line] __would__would not like Practice to provide me with an additional written __summary__explanation of such requested information at an additional cost to me of [$0.00].

_____ _____

Signature of Patient (or Personal Representative) Date

_____ _____

Printed Name of Personal Representative Relationship to Patient

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After you have completed this form please return it to the Office Manager by mail at the following address: 150 Broadway, Suite 1110, New York, NY 10038