健康資訊存取申請書

Patient Name: ______________________________

DOB: ____/_____/_____

Medical Record Number: ______________________________

Telephone Number: ______________________________

NYC Health + Hospitals 將使用此表格記錄您針對個人健康資訊的存取申請。

申請的存取方式： ☐ 複本 ☐ 現場查看

申請的格式： ☐ 紙本 ☐ CD ☐ 電子郵件 ☐ 其他：______________________________

釋出方式：

☐ 自取 / 本人親領 ☐ 傳送電子郵件至：______________________________

☐ 郵寄至：______________________________

所有申請均需填寫以下資訊

需要存取的資訊：

☐ 健康資訊（日期）____________________

☐ 實驗室檢驗結果（日期）____________________

☐ 帳單記錄（日期）：____________________

☐ 其他（請詳細說明）：______________________________

☐ 放射檢查報告（日期）____________________

☐ 病程記錄（日期）____________________

☐ 我的完整病歷

以下資訊僅在您於下方各適用類型中特別勾選時才會釋出：

☐ 物質濫用障礙資訊

☐ 基因檢測資訊

☐ 心理健康資訊

☐ HIV 相關資訊

我瞭解，我有權獲取所申請的形式和格式的個人健康資訊，前提是手邊已有此類形式和格式可生成，如果 NYC Health + Hospitals 手邊無法以我所申請的形式和格式生成個人健康資訊，將在雙方同意的基礎上為我提供可閱讀的紙本格式或此類其他形式和格式。

我瞭解，如果我申請電子版本的個人健康資訊且手邊已有該形式和格式的資訊可生成，NYC Health + Hospitals 將為我提供；如果不能，將在雙方同意的基礎上以可閱讀的電子格式和形式為我提供。

我瞭解，如果我申請現場查看個人健康資訊，與該資訊相對應的健康資訊管理部門將負責以合理、及時的方式協調進行。

我瞭解，如果我申請個人健康資訊複本，我可能需要為此支付合理的成本費用，並且收費前會告知我所有預估費用。我亦瞭解，不會將無法支付這類費用作為拒絕我申請存取健康資訊的唯一原因。

患者或個人代表簽名： 日期 / 時間：

如果不是患者本人，請清楚填寫個人代表的姓名、地址及電話號碼：

與患者的關係 / 代表患者行事的權限：

NAME OF EMPLOYEE PROCESSING REQUEST: ______________________________

EMPLOYEE SIGNATURE: ______________________________ DATE/TIME: ____________________

Request for Access to Health Information

Patient Name: ______________________________

DOB: ____/_____/_____

Medical Record Number: ______________________________

Telephone Number: ______________________________

NYC Health + Hospitals will use this form to document your request for access to your health information.

Access Requested: ☐ Copies ☐ Onsite Inspection

Format Requested: ☐ Paper ☐ CD ☐ Email ☐ Other: ______________________________

Method of Release:

☐ Pickup/In Person ☐ E-mail to: ______________________________

☐ Mail to: ______________________________

INFORMATION BELOW IS REQUIRED FOR ALL REQUESTS

Information to be Accessed:

☐ Health Information (date(s)) ____________________

☐ Radiology Reports (date(s)) ____________________

☐ Laboratory Test Results (date(s)) ____________________

☐ Progress Notes (date(s)) ____________________

☐ Billing Records (date(s)): ____________________

☐ My complete medical record

☐ Other (please specify): ______________________________

The following information will not be released unless you specifically select each applicable type below:

☐ Substance Use Disorder Information ☐ Mental Health Information

☐ Genetic Testing Information ☐ HIV-Related Information

I understand that I have the right to access my health information in the form and format requested if readily producible in such form and format, and that if NYC Health + Hospitals cannot readily produce such health information in the form and format requested, I will be provided a readable hard copy form or such other form and format as mutually agreed upon.

I understand that if I request an electronic copy of my health information, it will be provided to me if readily producible in such form and format, or if not, in a readable electronic form and format as mutually agreed upon.

I understand that if I request on-site inspection of my health information that the respective Health Information Management Department is responsible for coordinating such inspection in a reasonable and timely fashion.

I understand that if I request copies of my health information, I may be charged a reasonable cost-based fee for such request and that any fee estimates will be provided to me prior to being charged. I also understand that my inability to pay may not be used as the sole reason to deny a request to access my health information.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: DATE/TIME:

IF NOT PATIENT, PRINT NAME, ADDRESS AND PHONE NUMBER OF PERSONAL REPRESENTATIVE:

RELATIONSHIP/AUTHORITY TO ACT ON BEHALF OF PATIENT:

NAME OF EMPLOYEE PROCESSING REQUEST: ______________________________

EMPLOYEE SIGNATURE: ______________________________ DATE/TIME: ____________________