# Patient/Resident Request for Health Information

**Patient/Resident 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: | |
| Street Address: | City: | State: | Zip: |

**What records do you want? (Check appropriate boxes)**

***Include (initial):**___*HIV information* ___*Genetic Information* ___*Mental Health Information* ___*Drug /Alcohol Treatment*

Dates(s) of Service: ___/___/___ through ___/___/___

☐ Entire Record ☐ Discharge Summary ☐ Billing Records

☐ Other (Immunization Records, Medication Lists) please specify: _____

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**How would you like your records delivered?**

☐ Paper
☐ Electronic (Email, USB, CD, Other) Please specify: _____

☐ Home Delivery
☐ In-person Pickup

Where do you want the information sent? (Fill in boxes below):
St. Mary's should provide patient/resident' records to: ☐ Self ☐ Other individual (indicated below)

| | |
|---|---|
| Recipient name: | Recipient Phone:<br><br>Recipient Fax: |
| Recipient Mailing Address: | Recipient Email: |

**Please print your name and sign below:**

_____ _____
Name of patient/resident or Personal Representative (please print) Relationship (please print)

_____ _____
Signature of patient/resident or Personal Representative Date

**Please return completed form to:**

St. Mary's Hospital for Children
29-01 216th Street, Bayside, New York 11360
Email HIM@stmaryskids.org or Fax 516–240 –6436
ATTN: Health Information Management Department

*St. Mary's recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.*