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: _____

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: 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 Home Care
5 Dakota Drive, Suite 200, New Hyde Park, NY 11042
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.