APPLICATION TO INSPECT MEDICAL INFORMATION

You have the right to inspect certain medical and billing records. Please refer to the Erie County Notice of Privacy Practices for a more detailed description of your rights. To make a request to inspect your health information, please complete and return this form to:

Erie County Chief Privacy Officer
95 Franklin Street, Room 1634
Buffalo, NY 14202
Chief.Privacy.Officer@erie.gov

CONTACT INFORMATION

PATIENT NAME: ____
(please print)

PHONE NO.: ____

DATE OF BIRTH: ____________________

MAILING ADDRESS:____

EMAIL: ______________________________ DATE OF REQUEST: ____________

DESCRIPTION OF REQUEST

1. Please indicate which of the following department(s) of Erie County you would like to provide an accounting of disclosures:

- ☐ Department of Emergency Services
- ☐ Department of Health
- ☐ Department of Mental Health
- ☐ Department of Senior Services
- ☐ Department of Social Services
- ☐ Youth Services
- ☐ Other ______________________

2. Please describe the information you would like to inspect (include specific dates of service):

____

____

____

3. Please choose your preferred method of inspection:
   - ☐ I am requesting an opportunity to INSPECT the records described above. -OR-
   - ☐ I am requesting to obtain a COPY of the records described above. I understand that I will be charged $.25 per page, and that this charge is payable prior to receipt of requested record(s). -OR-
   - ☐ I am requesting to obtain an ELECTRONIC COPY of records described.

SIGNATURE AND VERIFICATION

I have read, understand and had an opportunity to ask questions about this form. I further understand that under certain circumstances, Erie County may deny this request. I understand that Erie County may charge me a reasonable cost-based fee for expenses such as copying, mailing or staff time related to this request.

SIGNATURE: ______________________________ **DATE:** ______________

NAME AND ADDRESS OF PERSONAL REPRESENTATIVE (if applicable):

____

PERSONAL REPRESENTATIVE'S AUTHORITY (supporting documentation is required):

☐ Parent
☐ Court-Appointed Guardian
☐ Health Care Agent
☐ Power of Attorney
☐ Administrator/Executor
☐ Other: ____________________

VERIFICATION REQUIREMENTS

For in-person requests for an amendment of health information, patients and authorized representatives can meet verification requirements with one of the following:

☐ In-person patient request verified by government-issued photo identification (copy of ID to be retained with request)
☐ In-person request by authorized third party - parent, legal guardian, or other court-appointed representative verified by government issued photo ID *and* copy of appointing document (copy to be retained with request)

Notarization is required for requests submitted to Erie County by mail. An authorized representative must also submit a copy of the appointing document. The notary public or other officer authorized to take and certify acknowledgments and administer oaths must complete the following:

STATE OF NEW YORK

COUNTY OF ______________

On the _________ day of ____________ in the year ________ before me, the individual referenced above, personally appeared and proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this form and acknowledged to me that he or she executed the same in his or her capacity, and that by his or her signature(s) on the form, the individual executed the form.

____
Notary Public
Printed Name: ________________________ My Commission Expires: ______________

FOR ADMINISTRATIVE USE ONLY: Date Received: ________ Request has been: ☐ Accepted ☐ Denied
Staff member: ______________________________ Title: ______________________