

Completion Date: _____

Attachment 19
Request for Access to Health Information

As a patient of a University of Miami provider or hospital, you may access certain health information we maintain about you. If you want to inspect and/or receive a copy of your health information, you must complete this form and return it to the appropriate Document/Records Custodian as indicated on page 2 of this form. Request applies only to the departments/Facilities that you indicate below.

To assist us in locating your information, please provide the following:

Date of Request: _____ Medical Record Number: _____
Patient Name: _____ Date of Birth: _____
Phone Number: _____ Last 4 Digits of SSN: _____
Address: _____ City: _____
State: _____ Zip: _____

I am requesting access to my health information maintained at:

Department: _____ Physician: _____
Facility/Hospital: _____

Please indicate whether you would like to inspect or receive a copy of your health information by checking the applicable box(es):

- I would like to inspect my health information in person at the University of Miami.
- I would like a copy of my health information.

Please indicate, by checking the appropriate box(es), the specific information to which you want access:

- Medical records (i.e., lab reports, progress notes, etc.) for the following dates:

- Films/Images (i.e., films, CDs, diagnostic images, etc.) for the following dates:

- Billing records (i.e., claims or statements) for the following dates:

We charge fees for copies, postage, and handling, as permitted by applicable state and federal law. You will be contacted with a total and instructed how to make payment as well as when you can expect to receive your records (if you have requested a copy).

Signature of patient or personal representative

Date

If personal representative, authority to act on behalf of patient/Relation to Patient

University of Miami – Office of HIPAA Privacy & Security
PO Box 019132 (M-879) hipaaprivacy@med.miami.edu
Miami, FL 33101 305-243-5000 1-866-366-4874

REQUEST FOR ACCESS TO HEALTH INFORMATION



Form
D3900018E

Revised
09/24/14

NAME: _____

MRN: _____

LAST 4 DIGITS OF SSN: _____

DOB: _____

DATE: _____

TIME: _____

How to Obtain your Medical Records

If you are requesting a copy of your medical records, you will be required to complete an Attachment 19 or Attachment 46 (3rd Party Authorization) form to obtain copies of your record. You may also be asked to provide a photo ID for identification purposes.

Please complete the form, fax, mail or contact the appropriate medical record department listed below:

University of Miami Hospital and Clinics (UMHC)/Sylvester Comprehensive Cancer Center (SCCC)

1475 N.W. 12th Avenue

Miami, Florida 33136

Phone: 305-243-5272

Fax: 305-243-5274 & 305-243-9521

Website: www.sylvester.org

Bascom Palmer Eye Institute (BPEI)/Anne Bates Leach Eye Hospital (ABLEH)

900 N.W. 17th Street

Miami, Florida 33136

Phone: 305-326-6333

Fax: 305-547-3709

Website: <http://bascompalmer.org/>

University of Miami Hospital (UMH)

1400 N.W. 12th Ave

Miami, FL 33136

Phone: 305-689-5605 & 305-689-5187

Fax: 305-689-4490 & 305-689-3995

Website: <http://www.umiamihospital.com/>

For any other clinical department, please contact the physician office directly.

For further assistance, please call 305-243-4000.

For privacy issues or concerns, please contact:

Office of HIPAA Privacy and Security

Phone: 305-243-5000 Outside of Dade County: 866-366-4874

Fax: 305-243-7487

Email: hipaaprivacy@med.miami.edu

Website: www.privacyoffice.med.miami.edu

P.O. Box 019132 (M-879)

Miami, Florida 33101

MyUHealthChart online portal

You may also access portions of your health information online through the MyUHealthChart portal. <https://myuhealthchart.com/mychart/>

For further assistance or to obtain access, email: AskMyUHealthChart@med.miami.edu