MEDICAL RECORDS REQUEST

THE OFFICE OF DR. ANDREW D. PEARLE

I, patient ________________________________, date-of-birth ____________, am requesting a copy of my medical records from the practice of **Andrew D. Pearle, MD**. If your office needs to contact me regarding this request, please call me at (________) ___________________________.

I would like my records:

☐ Mailed to the following address ______________________________________

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☐ Faxed to the following number (________) ____________________________

☐ Emailed to the following address ______________________________________

Records sent via email are sent [SECURE] ONLY!
This is per Hospital for Special Surgery policy and is for the protection of your private health information.

Please include the following:

☐ Office Notes

☐ Radiology Reports

********Record requests typically take 10-15 business days for processing********

THE ABOVE REQUEST DOES NOT INCLUDE RADIOLOGY IMAGES OR OPERATIVE REPORTS,
our office is not permitted to release these records. All radiology images (X-ray, MRI, CT, Ultrasound, etc.) must be obtained directly from the **HSS Radiology Record Room at (212) 606-1135.**
Operative reports must be obtained directly from the **HIM (Health Info. Mgmt)Department at (212) 606-1254.**
For **Dr. Pearle Billing Records,** please contact **Ivolution at (877) 893-5790.**

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
Parent/Guardian Signature (if patient is a minor) Date

This form may be faxed **(212) 774-2798,** emailed to drpearlefax@hss.edu
or mailed to **Andrew Pearle, MD, 535 E. 70th Street, NY NY 10021**