Cary Dermatology Center, P. A.

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

I hereby request Cary Dermatology Center, P. A. to provide me or the person listed below with access to all protected health information about me that is maintained by Cary Dermatology Center, P. A.. Specifically, I would like to:

- ☐ Inspect my protected health information;
- ☐ Inspect a summary or explanation of my protected health information;
- ☐ Obtain a copy of my protected health information; or
- ☐ Obtain a copy of a summary or explanation of my protected health information.

I would like to:

- ☐ Pick up the copy or summary/explanation I requested;
- ☐ Have Cary Dermatology Center, P. A. mail the copy or summary/explanation to me or to someone else at the address written below; or
- ☐ Receive the copy or summary/explanation on ___ paper or ___ CD or flash drive or __ by e-mail.

Patient name: _____ Date of birth: _____

Name of person to receive copy (if applicable): _____

Recipient's address: _____

Recipient's e-Mail address: _____

Patient's telephone: _____ Patient Number: _____

Dates of treatment: From _____ to _____

(Write ***"all"*** if you want information for all dates of treatment)

I understand that I **may be charged a fee** for the preparation of a summary or explanation of my protected health information. I also **may be charged a fee** for reproduction costs to obtain a copy of my protected health information or to obtain a copy of the summary or explanation. If I ask to have the information mailed to me, I understand that I **may be charged a fee** for mailing costs. If I ask for an electronic copy of my protected health information, I understand that I **may be charged a fee** for the media (CD, flash drive) on which my copy is stored and provided to me and for the labor costs associated with making the copy. If I ask to have information e-mailed to me or another person, I understand that sending e-mails is not always secure, and I agree that I will not hold Cary Dermatology Center, P. A. responsible if the information e-mailed is intercepted by an unauthorized third party.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

Relationship of Representative to Patient (please describe Representative's authority to act on behalf of the Patient):

_____

_____