Raleigh Skin Surgery Center, pllc

ACMS American College of Mohs Surgery
Fellowship trained skin cancer and reconstructive surgeons

3811 Ed Drive; Suite 110 • Raleigh, NC 27612 • Phone: (919) 390-0200 Fax: (919) 390-0219

Request for Access to Personal Health Information

Patient Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

☐ I would like a copy of my health information – I understand I may be charged a *fee.
☐ I would like for my health information to be provided to a third party – I understand I may be charged a *fee.

Name of third party: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

*We reserve the right to charge for medical record requests in accordance with the fee structure as set forth in the North Carolina state statute. You will be responsible for paying this fee prior to mailing or pick-up of these records. By signing this authorization, you are agreeing to pay Raleigh Skin Surgery Center, pllc for your records. The fees set forth by North Carolina statute are $.75 for pages 1-25, $.50 for pages 26-100, and $.25 for pages in excess of 100. We may impose of minimum fee of $10.00.

Records to be included in this request:

☐ Medical History ☐ Billing ☐ Consult Notes
☐ Mohs Notes ☐ Progress Notes ☐ Pathology
☐ Photos (please specify): _____
☐ Other: _____

Select the format you would prefer:

☐ **PAPER**: ☐ **ELECTRONIC**: ☐ **FAX NUMBER**:
☐ Mail to designated address ☐ Patient Portal _____
☐ Will pick up at RSSC ☐ Email*: _____

* For **email communication**, I understand that since information will not sent in an encrypted manner there is a risk it could be accessed inappropriately. By providing my email address I elect to receive email communication as requested.

You will receive notification regarding this access request no later than 30 days from the date received. There are limited circumstances in which your request may be denied, some of which you may have the right to request a review of the decision.

_____ _____
Signature of Patient or Personal Representative (attach necessary documentation) Date

This must be filled out for each records request.

Office Use Only:

☐ Records Sent Date: _____ Initials: _____

Patient Label