

## 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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Medical History                | <input type="checkbox"/> Billing        | <input type="checkbox"/> Consult Notes |
| <input type="checkbox"/> Mohs Notes                     | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Pathology     |
| <input type="checkbox"/> Photos (please specify): _____ |   |  |
| <input type="checkbox"/> Other: _____                   |   |  |

### Select the format you would prefer:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>PAPER:</b>              | <input type="checkbox"/> <b>ELECTRONIC:</b> | <input type="checkbox"/> <b>FAX NUMBER:</b> |
| <input type="checkbox"/> Mail to designated address | <input type="checkbox"/> Patient Portal     | _____                                       |
| <input type="checkbox"/> Will pick up at RSSC       | <input type="checkbox"/> 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