

CENTRAL CAROLINA DERMATOLOGY CLINIC, INC.
Request to Access and Copy Information

I am requesting to review my protected health information.

Patient Name: _____ DOB: _____

Patient Address: _____

City-State, Zip: _____

Requestor (if other than patient): _____

Legal Authority of Requestor: (attached necessary documentation such as power of attorney)

Home Phone: _____ Work Phone: _____

Information to review: _____

Dates of information to review: _____

The HIPAA Privacy Rule requires a response within 30 days with one 30-day extension allowed.

We will respond within 10 days of receipt of a request and again at 30 days as needed.

Signature of Patient or Representative

Date

There may be a fee associated with
this request. Please initial _____