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## Request for Access to Personal Health Information

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City-State, Zip: \_\_\_\_\_

Home or Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_

I would like a copy of my health information – I understand I may be charged a reasonable cost based fee.

I would like for my health information to be provided to a third party:

○ Name, address and phone number of third party: \_\_\_\_\_

Please specify the records included in this request:

\_\_\_\_\_  
\_\_\_\_\_

Select the format you would prefer (select one):

Paper

Mail to above address

Will pick up at the practice

Electronically

Patient Portal

E-mail

Fax Number: \_\_\_\_\_

○ E-Mail Address: \_\_\_\_\_

○ For e-mail communication, I understand that if information is 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.

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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

Date: \_\_\_\_\_

Please attach description of Personal representative's Authority, with necessary documentation

*Please send completed forms by fax, 919-510-5090, by mail, to Blue Ridge Dermatology Associates, 4225 Blue Ridge Rd, Suite 300, Raleigh, NC 27607, or by secure email to [contact@brdermnc.com](mailto:contact@brdermnc.com)*

Blue Ridge Dermatology Associates, P.A. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**For office use only:**

Date Received: \_\_\_\_\_

**Request Denied**

If denied, provide reason(s):

- The access is reasonably likely to endanger the life or physical safety of the individual or another person.
  - This ground for denial does not extend concerns that the individual will not be able to understand the information or may be upset by it.
- The access requested is reasonably likely to cause substantial harm to a person (other than a health care provider) referenced in the PHI.
- The provision of access to a personal representative of the individual that requests such access if reasonably likely to cause substantial harm to the individual or another person.
- Records no longer available (records destroyed > 10 years)

Unreviewable grounds:

- Request is for psychotherapy notes, or information compiled in reasonable anticipation of, or for use in, a legal proceeding.
- An inmate request a copy of their PHI and providing the copy would jeopardize the health, safety, security, custody, or rehabilitation of the inmate or other persons at the institution. An inmate retains the right to inspect their PHI.
- The PHI is part of a research study still in progress provided the individual agreed to the temporary suspension of access.
- The PHI was obtained by someone other than a health care provider (e.g., family member of the individual) under a promise of confidentiality and providing access to the information would be reasonably likely to reveal the source of the information.

Date individual notified: \_\_\_\_\_

By: \_\_\_\_\_

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**Request Accepted**

Date information provided as requested:

- |   |  |
|---|--|
| <input type="checkbox"/> Mailed: _____              | <input type="checkbox"/> Faxed: _____                      |
| <input type="checkbox"/> E-mailed: _____            | <input type="checkbox"/> Directed to patient portal: _____ |
| <input type="checkbox"/> Picked up in office: _____ | <input type="checkbox"/> Other: _____                      |

Requested Processed by: \_\_\_\_\_