Atlanta Center for Dermatologic Diseases, P.C.

ACCESS TO PROTECTED HEALTH INFORMATION

SECTION A: Patient to complete the following information

Date: _____ Requestor_____
Name:_____
Patient Name: _____ Medical Record Number_____
Address:_____

REQUEST:I hereby request that the Practice provide me with access to my Protected Health Information as checked below. **(Check all that apply)**:

____The entire Medical Record (all information) to the above-named requestor

____Progress Notes
____Nurse Notes
____Lab Results
____Operative Report
____Pathology Report
____Other (Describe as specifically as possible)

I request access to my health information as indicated above covering the dates _____ through _____ **(Please fill in dates)**

Type of Access Requested

_____ Inspection of requested information at Atlanta Center for Dermatologic Diseases, P.C.

_____ Copies of requested information maintained by Atlanta Center for Dermatologic Diseases, P.C.

_____

Signature of Patient or Personal Representative

I understand that this will include information to:

- Acquired Immunodeficiency syndrome (AIDS) human Immunodeficiency virus (HIV) infection
- Behavioral health service/psychiatric care
- Treatment for alcohol and/or drug abuse

_____

Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Date Received:_____
PO Initials: _____