



Vision Dermatology

3200 Blue Ridge Rd, Suite 118 • Raleigh, NC 27612 • Phone: (919) 439-1901 • Fax: (919) 439-1906

Request for Access to Personal Health Information

Patient Name: _____ **DOB:** _____

Address: _____

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

■ **I would like my health information released from the following provider/organization(s):**

- _____

- _____

■ **I would like my health information to be released to:**

Organization: Vision Dermatology Phone: 919-439-1901
 Address: 3200 Blue Ridge Road, Ste. 118 Fax: 919-439-1906
Raleigh, NC 27612

Information authorized for disclosure:

- Complete Medical Record Billing Consult Notes
- Mohs Surgery Notes Progress Notes Pathology Reports
- Other: _____

Select the format you would prefer:

EMAIL: VisionDermDirectMail@rssc.emadirect.md **FAX NUMBER:** 919-439-1906

* For **email 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.

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

Office Use Only: Records Sent Date: _____ Initial: _____