VISION
DERMATOLOGY
3200 BLUE RIDGE RD. STE 118.
RALEIGH, NC 27612
919-439-1901 PH
919-439-1906 F

Request for Access to Personal Health Information

Patient Name: _____ **DOB:** _____

Address: _____

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

■ Blue Ridge Dermatology, PA
Fax: 919-510-5090

☐ _____

_____

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

Name of third party: Vision Dermatology

Address: 3200 Blue Ridge Road, Ste. 118

City: Raleigh State: NC Zip: 27612

Phone Number: 919-439-1901 Fax Number: 919-439-1906

Records to be included in this request:

■ Complete Medical Record ☐ Billing ☐ Consult Notes
☐ Mohs Notes ☐ Progress Notes ☐ Pathology
☐ 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

This must be filled out for each records request.

Office Use Only:
☐ Records Sent Date: _____ Initials: _____

Maureen L. Aarons, MD, FAAD
Diplomate, American Board of Dermatology
Director of Dermatology, Vision Dermatology