

REQUEST TO REVIEW/COPY PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Name: _____
Last First MI

Account No: _____ Date of Birth: _____

1. I am submitting this form to request access to, or obtain a copy of, my or my minor child's medical and/or billing records created by the Dermatology Physicians of Connecticut (Practice). I understand I may be charged a reasonable cost-based fee for copies of the records. Applicable postage fees may also apply. My request will be processed within 15-days of the practice's receipt of my completed request and records will be mailed to the below address, unless otherwise indicated. If the practice does not maintain my records, I will be informed where to direct my request, if known. I understand the Practice does not fax records.

2. Check the box indicating how you would like to receive the records:

Mail to my current address: _____

Pick-up (you will be required to provide photo-identification at the time of pick-up.) Please provide a phone number where we may contact you when copies are ready for pick up.
(____) _____

Review in-person (you will be required to provide photo-identification at the time of the review.) Any review of patient records will be conducted in the presence of a Practice employee. Please provide a phone number where we may contact you to schedule an appointment.
(____) _____

3. Indicate the types of records you would like to receive and the date(s) of service for those records.

- Types of records: _____
- REQUIRED: Date(s) of service or date range of the records you are requesting
From date: _____ To date: _____

Signature: _____ Today's Date: _____

Printed Name: _____ Phone Number: _____

Address: _____
Street City State Zip Code

Please return the completed form for processing to the Dermatology Physicians of Connecticut Privacy Officer at the address below.

Effective Date: April 1, 2013