Request for Access to Protected Health Information

Under the Privacy Rule, you or your designated personal representative have the right to access your protected health information (PHI) for the purposes of inspection and/or obtaining a copy. There are certain conditions under which we are permitted to deny access to your PHI. If relevant, any conditions of denial will be explained to you.

Whose patient information is being released?

Patient Name	Date of Birth	Last 4 Digits of SS#	
Address	City	State	Zip

Requesting records **Sending records**

Send Records To	Request Records From

Location	Contact Name	Name/Organization
Address	City	State
Phone	Fax	Zip

If we are requesting records from you, please return to:

Fax #	Attn.
Outside Studies Can Be Mailed To	

What records or reports should be released?

Dates of Service ______________________________

Laboratory Results   Pathology Reports   Surgical/Procedure Reports   Clinic Notes

Billing Records   All Medical Records   Other: ______________________________

What is the purpose of the release?

Insurance   Personal   Treatment/Continuity of Care   Legal

Other: ______________________________

What format and delivery method would you prefer?

Digital/Electronic   Paper

The information disclosed may be subject to re-disclosure by the recipient and will no longer be protected by the Privacy Protections, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, and may no longer be protected by the Health Insurance Portability and Accountability Act Private Rule (45 CFR Part 164), and the Privacy Act of 1974 (5 USC 552a).

- I hereby authorize ______________________ and/or their business partners to disclose/release medical records and/or other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable for legal, insurance, and/or personal use.
- I hereby release ______________________ and/or their business partners from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released. I understand that I may revoke this authorization by providing written notice of my intention. Unless withdrawn, this consent will expire in thirty (30) days from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse, Genetic, HIV/AIDS and sexually transmitted disease information.

I authorize that this information may be faxed to the requesting Health Care Provider.

***Secure Communication -** Note that Regular email and some fax transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not include the entity's email address or fax number if this is of concern to you.

______________________________ Signature of Patient or Legal Representative

______________________________ Date

______________________________ If Signed by Legal Representative, Relationship to Patient

______________________________ Signature of Witness (If Applicable)

Please email to medicalrecords@rcderm.com, fax to 515-223-9341 or mail to RC Dermatology, 6800 Lake Drive, Suite 285, West Des Moines, IA 50266 rcderm.com