NORTHEAST DIGESTIVE

PATIENT ACCESS REQUEST FORM

ATTENTION: RELEASE OF MEDICAL INFORMATION

HIPPA regulations allow you to continue to release information without the patient's authorization. Section 164.506 © (4): "*A Covered Entity may disclose protected health information to another covered entity for health care operation activities of the entity that receives the information"*

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____

Home phone or Cellphone #: _____

PURPOSE OF RELEASE:

☐ Cancer Policy ☐ Copy of Record ☐ Legal/Insurance Review ☐ Authorized Representative's Request

☐ Other_____

RELEASE TO/FROM: The facility / practice/ individual listed below is authorized to release the requested health information for the following dates of service/range of time, event(s): (MM/DD/YY) _____

Facility/Practice Name: _____

Facility/Practice Address: _____

Telephone #: _____ **Fax #:** _____

Email address: _____

Release Method Requested: ☐ Mail ☐ Fax ☐ Email ☐ Other: _____

PATIENT'S RIGHTS AND SIGNATURE:

I understand that I have a right to revoke this authorization at any time by notifying the Medial Record Department of the above-named organization in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)

I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I may request to obtain a copy of the information to be used or disclosed per DGOC's Notice of Privacy Practices/Policy. Dermatology Group of the Carolinas, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that emails and texts are not always secure ways to communicate and could be intercepted and ready by a third part. I am willing to accept this risk. Northeast Digestive Health is not responsible for the privacy or security of your health information after it is sent to you, or others listed on this form.

This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document.
If the patient is minor or is clinically unable to sign, an authorized representative may sign this authorization.

Our office will let you know about this access request within 30days after it is received by this office. There are limited situations where your request may be denied. You will receive an explanation for any denials. You can ask for a review/appeal of a denied request for certain situations.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed name and description of Personal Representative's Authority (e.g., healthcare power of attorney) **Date**

(Attach documentation to support the personal representative's authority if not already on file with the practice)

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