BRUMMITTE DALE WILSON, M.D. & ASSOCIATES
DERMATOLOGY, MOHS SURGERY, AESTHETIC & LASER SURGERY
Brummitte Dale Wilson, M.D. * Cornelie M. Jones, M.D. * Peter SantaLucia, M.D.
CERTIFIED BY THE AMERICAN BOARD OF DERMATOLOGY

REQUEST FOR PATIENT ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

I HEREBY REQUEST ACCESS TO HEALTH INFORMATION FOR: [REQUIRED]

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

Patient Address: _____
Street

_____ _____ _____
City State Zip

SCOPE OF ACCESS REQUESTED [REQUIRED]

I would like access to:

75¢ per page (+ postage) for one of the options listed below:

☐ Relevant Records deemed pertinent by your treating physician(s) from our Practice
☐ Pathology Reports - please specify biopsy/excision site _____ & approximate Date _____/_____/_____
☐ Progress Notes *(75¢ per page)* - please specify Date Range _____/_____/_____ through _____/_____/_____
☐ Other *(75¢ per page)* - please specify type of disease, accident, dates of treatment, or other portion of records in which you are interested

_____

_____

for the following purpose(s): [REQUIRED]

_____

_____

TYPE OF ACCESS REQUESTED [REQUIRED]

☐ Copies. I would like copies of all records requested.

☐ I would like the information in the following form or format: _____

_____

_____

Hamburg Medical Park • 17 Long Avenue, Suites 200 & 201 • Hamburg, New York 14075 • Phone: (716) 648-2770 • Fax: (716) 648-1552
www.BDWilsonMD.com

BRUMMITTE DALE WILSON, M.D. & ASSOCIATES
DERMATOLOGY, MOHS SURGERY, AESTHETIC & LASER SURGERY
Brummitte Dale Wilson, M.D. * Cornelie M. Jones, M.D. * Peter SantaLucia, M.D.
CERTIFIED BY THE AMERICAN BOARD OF DERMATOLOGY

CHARGES [REQUIRED]

Copies or Transfer. I understand that you may charge me a reasonable charge of up to $0.75 per page (plus any applicable postage) for copies. I understand that you cannot deny me either i) access to my records, or ii) copies of my records, solely because I am unable to pay your costs.

- ☐ I hereby agree to pay the charges specified above. Please bill me.
- ☐ Please call me to let me know the total cost that I will incur.
- ☐ I am unable to pay for the copies because (please state detailed reasons for the financial hardship):

_____

_____

_____

Signed: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient
- ☐ other (specify)

Name of Patient: _____

WITNESS [REQUIRED] State of _____ County of _____

On this _____ day of _____, 20_____, before me personally came _____ _____ known to me to be the individual above named who executed the foregoing authorization, and who duly acknowledged to me the execution thereof.

_____ _____/_____/20_____

Signature Of Witness [REQUIRED] **Date [Required]**

Hamburg Medical Park • 17 Long Avenue, Suites 200 & 201 • Hamburg, New York 14075 • Phone: (716) 648-2770 • Fax: (716) 648-1552
www.BDWilsonMD.com