Carolina Kidney Associates, PA

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

I hereby request Carolina Kidney to provide me or the person listed below with access to all protected health information about me that is maintained by Carolina Kidney. Specifically, I would like to:

☐ Inspect my protected health information;

☐ Inspect a summary or explanation of my protected health information;

☐ Obtain a copy of my protected health information; or

☐ Obtain a copy of a summary or explanation of my protected health information.

I would like to:

☐ Pick up the copy or summary/explanation I requested;

☐ Have Carolina Kidney mail or fax the copy or summary/explanation to me or to someone else at the address written below; or

☐ Receive the copy or summary/explanation on ___ paper or ___ electronically __ by e-mail.

Patient name: ____Date of birth: ______________

Name of person to receive copy (if applicable): ____

Recipient's address: ____

Recipient's e-Mail address: ____

Patient's telephone: ____________________________________Patient Number: __________________________

Dates of treatment: From ______________ to ________________

I understand that I **may be charged a fee** for the preparation of a summary or explanation of my protected health information. I also **may be charged a fee** for reproduction costs to obtain a copy of my protected health information or to obtain a copy of the summary or explanation. If I ask to have the information mailed to me, I understand that I **may be charged a fee** for mailing costs. If I ask for an electronic copy of my protected health information, I understand that I **may be charged a fee** for the media (flash drive) on which my copy is stored and provided to me and for the labor costs associated with making the copy. If I ask to have information e-mailed to me or another person, I understand that sending e-mails is not always secure, and I agree that I will not hold Carolina Kidney responsible if the information e-mailed is intercepted by an unauthorized third party.

_____________________________________ _____________________________

Signature of Patient or Representative Date

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Print Name

Relationship of Representative to Patient (please describe Representative's authority to act on behalf of the Patient):
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