

<b>Facility: Sunrise Dermatology</b>
<b>Address: 70 Midtown Park E., Mobile, Alabama 36606</b>
<b>Privacy Official: Christine Freeman</b>
<b>Telephone: 251-544-6407</b>

### Request for Access to Records

Notice to Patient: You may use this form to request to inspect or copy information maintained about you. This type of request is described in our Facility's Notice of Privacy Practices.

**Patient Name:** \_\_\_\_\_  
[print or type]

**Description of Records Requested:**  
*(Please describe the records or types of records requested. Please also let us know how far back in time you want access to records.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Scope of Request:**  
*(Please let us know if you want to: 1. inspect records; 2. copy records; or 3. both.)*

- \_\_\_\_\_ I would like to *inspect* the requested records.
- \_\_\_\_\_ I would like to obtain a *copy* of the requested records.
- \_\_\_\_\_ I would like to *both inspect and copy* the requested records.

**Fee for Copying Requested Records**  
Our Facility may charge a reasonable fee for the cost of copying your requested records. We may also charge you for postage if you ask us to mail your requested records.

**Contact Person**  
Please contact our Facility's Privacy Official if you have any questions relating to requests to inspect or copy records.

### Patient Information and Authorization

Print Name of Patient: \_\_\_\_\_  
Signature of Patient: \_\_\_\_\_  
Date: \_\_\_\_\_  
Date of Birth (for identification purposes): \_\_\_\_\_



For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: \_\_\_\_\_  
Describe Personal Representative Relationship (parent, guardian, power of attorney, etc): \_\_\_\_\_

*I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.*

Signature of Personal Representative: \_\_\_\_\_  
Date: \_\_\_\_\_