UNC | ADAMS SCHOOL OF DENTISTRY

Carolina Dentistry

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

You have the right to request access to protected health information about you that is maintained by the UNC Adams School of Dentistry, facilities, clinics, practices, departments and other sites of service (hereinafter "Carolina Dentistry"). Carolina Dentistry will evaluate your request and will either grant your request or explain the reason why the request will not be granted no later than thirty (30) days from receipt of your request. Carolina Dentistry may charge you a reasonable cost-based fee for your request. Your right to access does not extend to information complied in reasonable anticipation of litigation; psychotherapy notes; information not maintained by Carolina Dentistry; or other information not subject to the right of access under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule.

PART A: PATIENT INFORMATION

Patient Last Name:	Patient First Name:	Phone#:	Date of Birth:

Address:

Email Address:	SS# (last 4 digits):	MRN #:

PART B: SCOPE OF ACCESS REQUEST

Treatment Date(s): ☐Specific Dates from_____ to_____ ***OR*** ☐All Dates

Records or Information: ☐Abstract/Summary ☐Exam/Treatment Notes ☐X-Ray/Imaging ☐Billing Records ☐Entire Record

PART C: FORM, FORMAT, AND MANNER OF ACCESS REQUEST

☐ **Inspection.** I would like to inspect the above information at Carolina Dentistry during regular business hours (8:00 a.m.–4:30 p.m.).

☐ **Pick Up.** I would like to physically pick up the records at Carolina Dentistry. Please call me at _____ when pick up is available.

☐ **Mail or Fax.** Send by mail/fax to me at the following address/fax number _____

☐ **Encrypted Email.** Send by encrypted email to the following email address_____

***Fees:** If there are fees applicable to this request, Carolina Dentistry will provide written notification to the requester indicating what the cost will be. Prior to processing, requester is required to provide written response approving the fees and agreeing to payment. Fees may include charges for paper copies, certification fee (if requested), single retrieval fee, and actual shipping costs, if any.

PART D: PATIENT SIGNATURE OR PERSONAL REPRESENTATIVE

Patient signature or Personal Representative signature	**Date**

If personal representative: (1) print your name, (2) state the legal authority for your status as patient's personal representative, and (3) attach supporting documentation.

Submit Form

Email: sod-xrays@unc.edu
Phone: (919) 537-3888

Mail: Patient Records
Tarrson Hall CB#7450
Chapel Hill, NC 27599-7450

Fax: (919) 537-3625