M | D
MODERN DERMATOLOGY
WESTPORT, CT

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REQUEST TO REVIEW/COPY PROTECTED HEALTH INFORMATION

1. I am submitting this form to request access to, or obtain a copy of, my or my minor child's medical and/or billing records created by the Modern Dermatology of Connecticut (Practice). I understand I may be charged a reasonable cost-based fee for copies of the records. Applicable postage fees may also apply. My request will be processed within 15-days of the practice's receipt of my completed request and records will be mailed to the below address, unless otherwise indicated. If the practice does not maintain my records, I will be informed where to direct my request, if known. I understand the Practice does not fax records.

2. Check the box indicating how you would like to receive the records:

   ☐ Mail to my current address:

   ☐ Pick-up (you will be required to provide photo-identification at the time of pick-up.)
   Please provide a phone number where we may contact you when copies are ready for pick up.
   _____

   Review in-person (you will be required to provide photo-identification at the time of the review.)
   Any review of patient records will be conducted in the presence of a Practice employee.
   Please provide a phone number where we may contact you to schedule an appointment.
   _____

3. Indicate the types of records you would like to receive and the date(s) of service for those records.

   Types of records: _____

   Date(s) of service or date range of the records you are requesting

   From date: _____ To date: _____

Signature: _____

Printed Name: _____

Today's Date: _____

Phone Number: _____

Address: _____
street city state zip code

Please return the completed form for processing to the Modern Dermatology of Connecticut's Privacy Officer at the address below:
1032 Post Road East, Westport, Connecticut 06880