6419 Suite A Carolina Beach Rd
Wilmington, NC 28412

MASONBORO FAMILY MEDICINE

HIPAA Privacy Rights Request Form

PATIENT INFORMATION

Date

Name (Last, first, middle initial) | Date of Birth

Street address, City, ST, ZIP Code

Primary phone number | Other phone number | Email address

Type of Request

Access/copy	Amendment	Restriction
Confidential communication	Accounting of disclosures	Complaint

Please describe nature of action requested (type of information requested; nature of amendment, restriction, alternative communication, or complaint, etc.) in detail.

May we leave lab results on a voicemail? Y/N If yes, what is the preferred contact number?

Please list Names of individuals whom may receive any financial information, lab results and or medical history.

Name | Phone
Relation to Patient

Name | Phone
Relation to Patient

Name | Phone
Relation to Patient

Signature of Patient/Legal Guardian | Date

Signature of Witness | Date

THE ABOVE INFORMATION IS EFFECTIVE FOR 12 MONTHS. IF ANY CHANGES NEED TO BE MADE DURING THE 12 MONTHS, PLEASE ASK TO COMPLETE A NEW RELEASE.