

VISTA EYE SPECIALISTS
REQUEST FOR MEDICAL RECORDS

Patient Name: _____ DOB _____

I authorize Vista Eye Specialists to release information specified below to the party identified below or authorize the party identified below to release the requested information to Vista Eye Specialists (fax 888-393-5264).

RELEASE OF INFORMATION TO PERSON / ORGANIZATION AS NOTED BELOW

Name _____

Organization _____

Street Address _____

City, State, Zip Code _____

Information to be Released or Obtained

____ Physician's progress notes ____ Operative Notes

____ Ancillary testing (i.e. Visual fields, OCT) (please specify): _____

____ Other (please specify): _____

Dates of service _____ to _____

The purpose for disclosure of the above information is:

____ Continuing Care ____ Personal Use

____ Other (please specify): _____

I understand that I have the right to access my medical records in accordance with the law and the policies of the Medical Practice. I understand that the Medical Practice may charge me for copies of my medical records, and I have been provided a fee schedule.

I understand that the Medical Practice has the right to deny me access to my records in certain circumstances in accordance with the law. If the Medical Practice denies me access to my medical information, I understand it will provide me with the reason for the denial in writing and describe whether I have a review of the denial performed by a licensed health care professional.

Please note that information disclosed pursuant to this request is no longer under the control of the Medical Practice and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient _____ **Date** _____

Patient Representative _____ **Date** _____

Relationship to Patient _____

This request for medical records will expire one year from signature date.