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 INFORMATIONTO 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. **VA Law allows for copy charges consisting of the following: $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter, and $1.00 per page of microfilm/fiche.**

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*:*_____