



REQUEST FOR ACCESS TO MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Dear Patient:

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them. The Eye Clinic of Austin uses and provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Eye Clinic of Austin will only include information used to make decisions about the patient. We will limit access to information generated only by this Practice. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information. A Compliance Officer (or designee) of this Practice will evaluate this request and notify you of our decision within fifteen (15) days. Reasonable costs will be charged for the request. Costs will be submitted to the patient (or agent) upon approval of the request. The Practice may provide a summary of the requested information if you are agreeable.

Dear Compliance Officer:

___ I would like to request from and authorize the Eye Clinic of Austin to release a copy of my medical records as indicated below to myself or the party also indicated below.

___ I would like to arrange an appointment to inspect the requested information.

I understand that there will be a cost charged to me (or my agent) for this service. I agree that a photocopy of this authorization may be considered valid and that this authorization shall be valid for 90 days from the date of my signature. I understand my rights and the Eye Clinic of Austin's policies regarding this release, as indicated above and in the Notice of Privacy Practices.

Health Care Information requested. Please provide dates, diagnosis, treatment, or any other indications of the specific information you desire: _____

Is a summary of the information acceptable? ___ YES ___ NO

Instructions regarding copies:

___ I will pick up the copies, when I have been notified that they are ready.

___ Please mail the copies to me at the following address: _____
Street Address

City / State Zip Home Phone Other Phone

___ Please mail or fax to: _____
Name of Recipient Street Address

City / State Zip Office Phone Fax

Patient / Guardian / Legal Representative Signature Date

Relationship to patient (if other than patient): _____ Contact Phone: _____