REQUEST FOR ACCESS TO MEDICAL INFORMATION

Dear Compliance Officer:

I, _____ , _____ would like to request from
Patient Legal Name Date of Birth

and authorize _____ located at _____
Provider or Providers office Street

_____ ___(_____)_____
City, State Zip Telephone

A copy of my medical records as indicated below to be released to **EYE CLINIC OF AUSTIN 3410 Far West Blvd, Suite 140Austin, Texas 78731**. I understand that there may be reasonable costs charged to me for this service.

Health care information requested. (Please provide dates, diagnosis, treatment, or any indications of the specific information you desire**):** _____
_____
_____
_____

Is a summary of the information acceptable? _____Yes _____No

I, the patient, 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, the patient, understand that I may revoke this authorization in writing at any time prior to the expiration date.

_____ _____
Patient / Guardian / Legal Representative Signature Date

Patient contact phone: _____

Relationship to patient (if other than patient):_____

The Eye Clinic of Austin uses and provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Medical Records: (512) 427-1106 Fax (512) 427-1208 Revised: 2/20/08