REQUEST FOR ACCESS TO MEDICAL INFORMATION

According to federal law, this form must be filled out completely. This form cannot be edited after it is signed.

Patient Name:____

Date of Birth:________________ Phone: __________ Email:________________________

Address:________________________City:________________ State:_______Zip:_______

I, the undersigned, authorize Mattax Neu Prater Eye Center to:

☐ **RELEASE RECORDS TO** ☐ **OBTAIN RECORDS FROM**

Name:_____________________________________ Phone: ________________________

Address:______________________ City:__________________State:______ Zip:________

Email: ____Fax: _______________________

Preferred delivery method (choose one): ☐ MAIL ☐ FAX ☐ EMAIL ☐ I will pick up the records

Information Requested: ____

Signature of patient / authorized party: ______________________________ Date: __________

Printed name: _____________________ Relationship to patient:________________________

The Notice of Privacy Practices provides information about our use of protected health information and is available on request. 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 Practice will only include information used to make decisions about the patient. The Practice may 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. The Compliance Officer of this Practice will evaluate this Request and notify the patient of our decision within fifteen (15) days of this Request. If the Request is approved, the Practice will provide the information within thirty (30) days or within sixty (60) days if such an extension is necessary. Reasonable costs will be charged for the Request. Costs will be submitted to the patient upon approval of the Request. The Practice may provide a summary of the requested information if you are agreeable.

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

-For Office Use Only-

Received by:____________________ **Date:**________________ ☐ **ID Confirmed**