HIPAA COMPLIANT REQUEST FOR MEDICAL RECORDS

DATE OF REQUEST: _____

PATIENT INFORMATION

Patient Name (Print):	
Patient Identification:	Social Security No. Date of Birth Medical Record
Reason for Request:	

Name and address of Doctor/Facility where patient's medical records are located:

Name:	
Address:	
Telephone:	
Fax:	

SEND THE FOLLOWING RECORDS (See Dates):

☐ All Medical Records (See below for restrictions) for following dates: _____
☐ Other:_____

SEND SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:

Name:	Comprehensive Eye
Address:	200 Mosaic Circle, Pooler, GA 31322
Telephone:	912-348-4584
Fax:	912-348-4585

I, (Patient Print Name) _____, hereby request and authorize medical records and tests results to be photocopied, released and mailed/faxed to the indicated address above for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) applies to my medical records and my protected health information. I expect the holder of my medical records to mail/fax my specified medical records as soon as reasonably possible, not to exceed 30 days, unless my records are off-site which allows for an additional 30 days. This authorization may be revoked by me, at any time, by notifying the doctor's office (privacy officer) of this revocation in writing. I have been advised that if I chose to not authorize that I will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payments.

☐ I HAVE NO PROTECTED HEALTH INFORMATION FOR THE SPECIFIED TIME FRAME release all of my medical records that have been indicated above.
☐ I HAVE PROTECTED HEALTH INFORMATION WITHIN THE AUTHORIZED TIME FRAME release all of the above medical records for the specified time frame except for the following _____

Signature of Patient:_____Date:_____

Expiration Date for this Authorization: _____