REQUEST FOR ACCESS TO MEDICAL INFORMATION

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 healthcare information used to make decisions about them.

Oregon Eye Consultants, LLC, (OEC) will only include information used to make decisions about the patient. OEC 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 Privacy 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, OEC 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. OEC may provide a summary of the requested information if you are agreeable.

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

Patient Name: ________________________________ D.O.B: ________________

Reason for releasing medical information: ________________________________
Photo ID verified: __________

I specifically authorize the release of the following information:

Treatment for the following diagnosis: ________________________________
(Specific diagnosis)

Chart Notes – Specific Dates: From ____________ To ____________

Special testing and photographs: Correspondence Operative reports

Is the summary of the information acceptable? Yes No
To **exclude** the following two categories from the requested records, initial below:

HIV/AIDS records: ____________________
(Initial here for **exclusion** only)
Alcohol or drug treatment records: ____________________
(Initial here for **exclusion** only)

Please release my records **TO**: (*check one of the two listed below*)

Patient
I will pick up copies: ________________________________
Please mail the copies to me at: ________________________________
Please email the copies to me at: ________________________________

Doctor
Doctor's name: ________________________________
Address: ________________________________

Or:

Please request that my records be released **FROM**:
Doctor's name: ________________________________
Address: ________________________________

And, faxed to: Oregon Eye Consultants at 541-683-8779
Or, mailed to: 3783 International Court, Suite #290, Springfield, OR 97477

________________________________ ____________
(Signature of Patient) (Date)

________________________________ ____________
(Signature of Parent or Person Authorized by Law *(if other than patient)*) (Date)

Relationship to patient: ____