Medical Records Request Form

This form is intended for use by patients requesting a copy of their medical records for personal use or for delivery to another physician participating in their care.

Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, Brinton Vision will be unable to comply with the request.

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Request Statement: I request that Brinton Vision disclose the following health information about me as described below. (check all that apply)

- ☐ All Medical records
- ☐ Medical records only from _____ to _____ (please include date range)

Authorization: Brinton Vision is authorized to release the above indicated records to the indicated representative listed below.

- ☐ I authorize Brinton Vision to release my medical records directly to me.
  Email: _____
- ☐ I authorize Brinton Vision to release my medical records to the medical provider or clinic named below.
- ☐ I authorize Brinton Vision to release my medical records to the third party listed below who is not a medical provider.

Provider Name/Third Party:

Clinic: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

_____ Initial I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) and alcohol and drug use. I authorize release or disclosure of this type of information.

_____ Initial I understand the following:

a. I have the right to revoke this autorization in writing at any time, except to the extent information has been released in reliance upon the authorization.
b. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
c. Any copy or photocopy of this authorization shall authorize you to release the records requested herein.
d. This authorization shall be in force and effect until two years from the date of execution.

_____ _____

Patient Signature or Legally Authorized Representative Date