Medical Records Request Form

This form is for patients requesting a copy of their medical records for personal use or for delivery to another physician involved in their care. Please allow seven (7) business days for processing. 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. Once completed, email this form along with a color scan/photo of your current, government-issued photo ID (driver's license or passport) to info@brintonvision.com. Note that we do not have a fax machine or use fax.

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Mobile phone:_____

Email: _____

Request Statement: I request that Brinton Vision disclose the following health information about me as described below.

☐ Medical records only from _____ to _____ (specify date range)
☐ Medical records from all dates

Authorization: Brinton Vision is authorized to release my records as indicated above in the following manner (choose one). Note that for patient privacy and security reasons, we will only release records using the email address or postal address listed on your file in our medical records, which must match the information provided above.

☐ I authorize Brinton Vision to release my medical records directly to me by regular email.
☐ I authorize Brinton Vision to release my medical records directly to me by postal mail.

I understand and agree that the information to be released or disclosed may include sensitive information related to mental health and substance use disorders, reproductive and sexual health, genetic information, and communicable diseases. With my signature on this document, I authorize the release and disclosure of this sensitive health information.

I understand the following:
a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
c. Any copy 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.

By signing here, I acknowledge that I have read, understand, and agree with the information on this page.

_____ _____
Patient signature Date