

OPHTHALMOLOGY SPECIALISTS OF TEXAS

PATIENT ACCESS TO MEDICAL RECORD REQUEST FORM

I, _____, request access to my medical records for my personal inspection or by _____, my personal representative. (Please specify date of record you want access to)
Date _____ Time _____

OR:

I, _____, request OPHTHALMOLOGY SPECIALISTS OF TEXAS make copies of my medical records for my personal inspection. I understand that these records contain protected health information (PHI). I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable). The charge for this will be \$___ per page* and I will be charged a minimum of \$ _____. I agree to pay for this prior to the service being rendered.

Records requesting access to: Complete Medical Records ___ Billing ___ Labs/Test results ___ HIV ___
Follow-up Exams ___ Mental Health ___

Reason for request: _____

Patient Signature _____

Patient Printed Name and Date of Birth _____

Date of request _____

PRACTICE RESPONSE TO REQUEST (MUST BE WITHIN 60 DAYS OF RECEIPT OF REQUEST. TEXAS LIMITS TO 15 DAYS FOR REQUEST)

- Grants all or part of your request _____
- Denies all or part of your request _____

For the following reason: (Circle all that apply)

Not part of your designated record set; contains psychotherapy notes; information was compiled for civil, criminal or administrative actions; subject to CLIA; regards inmate at correctional institution; was created during research; is subject to Federal privacy act; was not created by this practice.

Patient may not appeal if denial is for any of the above reasons

Denied at the discretion of the practice as the information may be harmful to the Patient or a third party

Requests a 30-day extension to respond due to _____