



PATIENT REQUEST FOR RECORDS

Date Received at ECNF: _____

Received by: _____

Please complete the following personal information:

Patients Name: _____ DOB: _____

Patient Medical Record # if known _____

Patient Address: _____

Phone Number: (Home) _____ (Work) _____

Patient Signature: _____ Date: _____

Please indicate which of the following you are requesting:

Personal Access to Protected Health Information: See information on reverse of this page

I hereby request access to my protected health information. I would like to access this information by:

- _____ In office review of file. I understand that a member of the practice will be present during the review.
- _____ Mail-supply complete mailing address
- _____ Fax – supply working fax number
- _____ Pick Up Person authorized to pick up on my behalf _____

Transfer my Medical Records TO Another Doctor/Hospital/Facility – Send my records to the following address

To: _____

(Doctor/Hospital)

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Transfer my Medical Records FROM Another Doctor/Hospital/Facility

To: _____

(Doctor/Hospital)

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

**I authorize the release of all records necessary for my eye care needs.
Authorization is valid for 60 days.**

**Please send the records to:
The Eye Center of North Florida
2500 Martin Luther King Jr Blvd
Panama City, FL. 32405
(850) 522-9829 (fax)**

The following are the practice's policies and procedures with regard to request for access to protected health information:

The practice will respond to requests for access as follows:

1. We will respond within thirty (30) days if granting the request or withholding information under the denial process.
2. We will respond within sixty (60) days if the information is not held or accessible on-site – this applies whether all or only part is off-site.
3. We will provide access in the format or manner requested by the individual or, if that is not possible, in a format or manner agreed to by the individual and this practice.