Miramar Eye Specialists Medical Group

11/2018

3085 Loma Vista Road • Ventura, CA • Ph (805) 648-3085 • Fax (805) 648-7027

Authorization To Release Medical Records

As required by the Health Information Portability and Privacy Act (HIPPA) of 1996 and California law, you have a right to request the opportunity to inspect and copy health information that pertains to you. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civil criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

Patient Name: ____ **Date of Birth:** ___________________________
(please print) (please print)

PLEASE RELEASE A COPY OF MY MEDICAL RECORDS:

FROM	TO
Name: ________________________________	**Name:** ________________________________
Address: ______________________________	**Address:** ______________________________
____	____
Tel: ( ) ____________________________	**Tel:** ( ) ____________________________
Fax: ( ) ____________________________	**Fax:** ( ) ____________________________

( ) All Records
( ) Most Recent Exam
( ) Records Since (date): __________________
( ) Glasses/CL Prescription
( ) The Portion of my Records Concerning: ________________
( ) This Authorization Request Expires: __________________

THERE IS A MINIMUM FEE OF $15.00 THE FEE IS COLLECTED BEFORE RECORDS ARE COPIED

NOTICE

Miramar Eye Specialists Medical Group and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create PHI to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the appropriate office of Miramar Eye Specialists Medical Group. The revocation will take effect when it is received, except to the extent that it has already been relied on.
- I am entitled to receive a copy of this Authorization**.**

SIGNATURE

_________________________________ _____________________ Date: ______________ Time: __________
Signature of Patient / Legal Representative   Relationship to Patient
(if signed by someone other than the patient)

____ (________)____________________________________
Print Name   Phone Number (Include Area Code)

____ Date: ______________ Time: ______________
Signature of Witness / Interpreter (only if patient unable to sign)