CONEJO-SIMI EYE MEDICAL GROUP

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REQUEST FOR MEDICAL RECORDS

As required by the *Health Information Portability and Privacy Act (HIPPA)* of 1996 and California law, you have a right to request theopportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why your request is denied. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civilcriminal or administrative action or proceeding, or to information we received in confidence from soneone other than another health care provider.

PLEASE RELEASE A COPY OF MY MEDICAL RECORDS:

FROM:	TO:
Name:	Name:
Address:	Address:
City, St, Zip	City, St, Zip
Tel: ( ) Fax: ( )	Tel: ( ) Fax: ( )

PLEASE PROVIDE:

( ) All Records
( ) Most recent exam
( ) Records Since (date) : _____

( ) Contact lens / glasses prescription
( ) The portion of my records concerning: _____

***** THERE IS A MINIMUM FEE OF $15.00 EACH *****
***** THE FEE IS COLLECTED BEFORE ANY COPYING WILL BE DONE *****
( ) PLEASE CALL ME AND LET ME KNOW THE ACTUAL COST PRIOR TO COPYING MY RECORDS

Signature: _____ Date: _____

Tel: _____ Cell: _____

IF NOT SIGNED BY PATIENT, PLEASE INDICATE RELATIONSHIP TO PATIENT:

( ) Parent or guardian of minor patient
( ) Guardian or conservator of incompetent patient
( ) Beneficiary or personal representative of deceased patient

Date rec'd:	Date paid: $
Date Patient was called:	Date sent/given:
Dates copied:	Copied by: