CONEJO-SIMI EYE MEDICAL GROUP

☐ **AGOURA OFFICE**
5643 KANAN ROAD AGOURA HILLS, CA 91301 TEL: (818) 889-2020 FAX: (818) 706-0288

☐ **THOUSAND OAKS OFFICE**
351 ROLLING OAKS DRIVE, SUITE 102 THOUSAND OAKS, CA 91361 TEL: (805) 497-3744 FAX: (805) 497-1663

☐ **SIMI VALLEY OFFICE**
2045 ROYAL AVENUE, SUITE # 125 SIMI VALLEY, CA 93065 TEL: (805) 527-6720 FAX: (805) 527-1889

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 the opportunity 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 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:
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: _____

REVISED: 04/2016 (JJ)