PATIENT ACCESS TO MEDICAL RECORD REQUEST FORM

I, _____, request access to my medical records for my personal inspection or by _____, my personal representative. (Please request date and time requested for record access)
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_____

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 _____