# ***Vista Eye Specialists***

## Request for Medical Records

Patient Name:_____ Date of Birth:_____

I authorize Vista Eye Specialists to release information specified below to the party identified or authorize the party identified below to release the requested information to Vista Eye Specialists (Fax: 540-318-7844)

**Release of information to/from person or organization as noted below**

Name/Organization: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number & Fax Number: _____

**Information to be released or obtained**

_____ Physician's progress notes _____ Operative Notes

_____ Ancillary testing (i.e. Visual Fields, OCT) (please specify) _____

_____ Other (please specify) _____

Dates of Service _____to _____

The purpose of disclosure of the above information:

_____ Continuing Care

_____ Other (please specify)_____

I understand that I have the right to access my medical records in accordance with the law and the policies of the Medical Practice.**VA LAW allows for charges consisting of the following: $20.00 for search and handling administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter, and all postage and shipping costs.**

I understand that the Medical Practice has the right to deny me access to my records in certain circumstances in accordance with the law. If the Medical Practice denies me access to my medical information, I understand it will provide me with the reason for the denial in writing and descried whether I have a review of the denial performed by a licensed health care professional.

*Please note that information disclosed pursuant to this request is no longer under the control of the medical practice and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

Signature of Patient: _____Date: _____

Patient Representative: _____Date: _____

Relationship to Patient: _____Date: _____

*This request for medical records will expire one year from signature date.*