Center For Sight of Northwest Florida, PA
6190 N. Davis Hwy.
Pensacola, FL 32504
Fax (850)476-2059

Request for Medical Records

Under the Privacy Rule, you or your designated personal representative have the right to access your protected health information (PHI) for the purposes of inspection and/or obtaining a copy. There are certain conditions under which we are permitted to deny access to your PHI. If relevant, any conditions of denial will be explained to you.

If you prefer to receive copies of your records instead of us sending them on your behalf, we may charge a reasonable, cost-based fee. If a copy fee applies, the amount will be communicated when the records are ready to be picked up or mailed to you.

Who do you want us to release your records to?

Individual/Entity Name: _____

Address: _____

Phone/Fax *: _____ / _____

Email *: _____

OR

Who do you want us to request your records from?

Individual/Entity Name: _____

Address: _____

Phone/Fax *: _____ / _____

Email *: _____

* **Secure Communication** - Note that regular email and some fax transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not include the entity's email address or fax number if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, send only the following:

_____

_____ _____
Patient name Date of Birth

_____ _____
Patient signature Date