Retina Vitreous CENTER PC
246 Catalina Drive, Suite 1, Ashland, OR 97520 • Phone (541) 488-3192, Fax (541) 488-0646

REQUEST FOR ACCESS TO HEALTH INFORMATION

Patient Name _____ Date _____

Date of Birth _____ Telephone _____

Social Security No. _____

We are requesting health information in the following records:

- ☐ Full Medical Records Including any Infections such as Hepatitis and HIV
- ☐ Limited Medical Records (Date range): _____
- ☐ Billing Records (Date range): _____
- ☐ Diagnostic Tests: _____
- ☐ Other _____

Please provide the information in the following way:

- ☐ Mail to: Name _____
  Address _____
  _____
  _____
- ☐ Fax to: Name _____
  Fax Number _____

Reason for Request: _____

_____ _____
Signature of Patient or Guardian* Print Name of Patient or Guardian

* If this request is being signed by an individual's personal representative, please state the basis for the representative's authority: _____ (e.g., state law, court order, etc.).

For Office Use Only

Date	Items to Send	Sent (✓)	Sent to	Reason	Dr. Initials	Initials