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.).

NOTE: THERE MAY BE A $10 CHARGE PER RECORDS REQUEST.

For Office Use Only

Date	Records/Test(s) to Send	Eye(s)	Sent(✓)	Sent to	Dr. Init.	Tech Init.