Retina Institute of Virginia

REQUEST FOR MEDICAL RECORDS

Patient Name: ____

Physician Name: ____

Records should be delivered to (indicate if in-office access is requested):

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Information or Records Requested: ______________________________

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I understand that I have the right to access my medical records in accordance with the law and the policies of the Medical Practice. I understand that the Medical Practice may charge me for copies of my medical records, and I have been provided a fee schedule.

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 describe 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_____________________

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