PERSONALEYES
VISION CARE

Medical Records Request

This form is used to request medical records FROM another provider TO Nalini Healthcare PLLC.

RECORDS TO BE RELEASED FROM:

Provider/Entity: _____

Address: _____

City / State / Zip: _____

Phone: _____ Fax: _____

Secure Email: _____

PATIENT INFORMATION:

I _____ (patient full name) authorize the above-named provider/entity to release the following designated medical information.

INFORMATION REQUESTED:

___ Copy of complete medical records including results of diagnostic testing
___ Copy of contact lens prescription
___ Copy of spectacle lens prescription
___ Past/Present Medications
___ Blood Workup Results
___ Fundus Photography / OCT Images
___ Progress Notes
___ Radiology Reports
___ Other: _____

RELEASE RECORDS TO:

PersonalEyes Vision Care
2600 Lakeside Parkway, Ste. 180
Flower Mound, TX 75022
Fax: (817) 665-3820
Secure Email: Info@personaleyestx.com

Reason for Release: Further treatment / continuation of medical care

IMPORTANT INFORMATION:

• **Expiration:** This authorization is valid until the earlier of the occurrence of the death of the individual, permission is withdrawn in writing, or ___/___/_____ (termination date).

• **Re-disclosure:** I understand the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

• I have the right to refuse to sign this Authorization.

• I have the right to receive a copy of this Authorization.

• I have the right to inspect or copy the protected health information to be used or disclosed.

• It is completely my decision to sign this authorization. Treatment will not be refused if I choose not to sign.

• I may revoke this authorization at any time by contacting in writing, fax, or email the Privacy Officer noted in the Notice of Privacy Practices.

• Fees/charges will comply with all laws and regulations applicable to release of information.

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

IF I AM SIGNING FOR A MINOR, MY SIGNATURE ATTESTS THAT I HAVE LEGAL AUTHORITY OVER MEDICAL DECISIONS FOR THE DESIGNATED MINOR.

_____ _____

Print Patient Name DOB (unless signing for minor)

_____ Date: _____ / _____ / _____

Patient or Legally Authorized Individual Signature

_____ _____

Printed Name (if signed on behalf of patient) Relationship / DOB of minor (if signing for minor)