Retinal Diagnostic Center

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□ 200 Jose Figueres Ave, Ste. 240 San Jose, CA 95116 Ph. (408) 937-0928 Fax (408) 254-8954
□ 1663 Dominican Way, Ste. 110-A Santa Cruz, CA 95065 Ph. (831) 476-5888 Fax (831) 476-5563
□ 65 Nielson St., Ste. 115 Watsonville, CA 95076 Ph. (831) 724-2626 Fax (831) 724-2676
□ 123 DiSalvo Ave, Ste. E, San Jose, CA 95128 Ph. (408) 418-2200 Fax (408) 418-2205
□ 8833 Monterey Road, Suite D, Gilroy, CA 95020 Ph. (669) 500-4955 Fax (669) 500-4956

Diseases & Surgery of the Retina, Macula, & Vitreous
www.retinaldiagnostic.com

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Request for Patient Access to Health Information

As required by the Health Information Portability Accountability Act of 1996 and California law, you have the right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

I hereby request access to health information for:

Patient's Name: _____Pateint's DOB: _____

Patient's Address: _____

SCOPE OF ACCESS REQUESTED

I would like access to: All Records with diagnostic imaging All diagnostic imaging only

All Records dating from: _____ to _____

Mail records to: _____

Fax records to: _____

FEES:

- $0 fee for all records faxed to another healthcare provider.
- $25 fee for all records mailed or given to patient.
- $25 fee for all forms required to be filled out by Retinal Diagnostic Center doctors. This includes, but is not limited to disability forms, insurance forms and travel forms.
- $25 fee for images to be put on an USB flash drive.

All fees must be paid prior to records being processed.

Signed: _____

Printed Name: _____

Telephone: _____ Date: _____

If not signed by patient, please indicate relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient (please attach power of attorney)

Beneficiary or personal representative of deceased patient (please attach power of attorney)

Name of Patient: _____ Date of Birth: _____