Eye Physicians Medical/Surgical Center, Inc.

681 Third Avenue, Chula Vista, California 91910

Phone: (619) 420-2111 Fax (619) 585-8130

PATIENT RECORDS REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

I hereby authorize the release of any/all of my medical records and access to my personal health information as indicated below.

- ☐ No restrictions, all information may be released.
- ☐ You may release all but the following information: ______________________________

RELEASE FROM: ______________________________

____

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The undersigned authorizes the **RELEASE** (by USPS, Fax, and/or in person) **TO** the following:

____
Name Phone #

____
Address

____
City State Zip Code

Patient Information:

____
Patient's Name Social Security # Date of Birth

____
Address

____
City State Zip Code Phone #

The undersigned has a right to revoke this authorization, unless revocation is precluded by law, by written request to the Privacy Office at Eye Physicians Medical/Surgical Center, Inc. The information used or disclosed may be subject to redisclosure by the recipient and thereby not protected by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996. The undersigned has the right to refuse to sign the authorization and no treatment, payment, enrollment or eligibility may be conditioned upon obtaining this authorization.

All medical records or other information regarding my treatment, hospitalization and/or outpatient care for my impairment(s).
Information about how my impairment(s) affects my ability to complete tasks and activities of daily living.
Information about how my impairment(s) affect my ability to work.

The undersigned will be provided with a copy of this authorization.

______________________________ ___/___/___
Signature of Patient or Patient's Authorized Representative Date

______________________________ ___________ ___/___/___
EPMSC Witness or Notary (if form leaves this office) Date