REQUEST FOR MEDICAL RECORDS
RICHMOND EYE ASSOCIATES, P.C.

Patient Name: _____ Chart #:_____

SS #: _____/_____/_____ D.O.B.: _____/_____/_____

Records released to: _____

Records released from: _____

Information or records requested: _____

I understand that I have the right to access my medical records in accordance with the Virginia Code policies of Richmond Eye Associates, P.C. I understand that Richmond Eye Associates, P.C. may charge me for copies of my medical records at a rate of $0.50 per page for the first 50 pages and $0.25 per page after 50 pages, a $10.00 search and handling fee plus all postage and shipping costs.

I understand that Richmond Eye Associates, P.C. has the right to deny me access to my records in certain circumstances in accordance with the law. If Richmond Eye Associates, P.C. denies me access to my medical information, I understand they will provide me with the reasons for denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.

Please note that the information disclosed pursuant to this request is no longer under control of Richmond Eye Associates, P.C. and may be subject to redisclosure by the recipient and may no longer be protected by federal state law.

Signature of patient: _____ Date: _____/_____/_____

Patient Representative: _____ Date: _____/_____/_____

Relationship to patient: _____

Witness: _____ Date: _____/_____/_____