HARVARD EYE ASSOCIATES

Celebrating 30 Years, 1975-2005

Request for Medical Records

Dear Dr. _________________________________(doctor sending records)

I request that my medical records, which may contain Personally Identifiable Information be forwarded to the address below. I understand that pursuant to the Health Insurance Portability Accountability Act of 1996, I must request specific dates of service or incidents of care, blanket releases will not be accepted.

Dates requested: ____

Incident of care requested ____

Harvard Eye Associates
Attention: Surgical Counselors
665 Camino de los Mares #102
San Clemente, CA 92673
Phone: (949) 493-5411 FAX: (949) 493-5726

____

Authorized Signature **Date**

____

Patients Signature **Date**

____

Please print patient's name **Date of Birth**

____

Patients Social Security Number