MARIETTA EYE CLINIC, PA & CHERRY STREET OPTICAL, INC
895 Canton Road, Bldg 100, Marietta, GA 30060
Phone (678)784-0219 / Fax (678) 784-0254

Request for Patient or Authorized Representative of Patient to Inspect and Copy Patient's Medical Records

(Does not authorize release of Medical Records to a Third Party)

THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR INFORMATION REGARDING YOUR RIGHTS TO SUCH REQUESTS.

Patient Name:
Address:
Phone Number:
Date of Birth:
Physician Name:

Please check one or both of the following, as appropriate:

❑ **Copy Request**

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $___.97_____ per page, with a minimum charge of $__________.

❑ **Access Request**

I wish to review my healthcare records maintained by the Practice. I understand that I must review my medical records at the offices of the Practice, in accordance with the Practice's policies and procedures. If I wish to have copies of my records made, I understand that I must submit a request for copies and that a fee will be charged for such copies, in accordance with the Practice's policies and procedures.

I understand that my healthcare provider is required by law to review the request(s) above and will determine if there are any reasons to deny such request(s). If my healthcare provider determines that I should not be given access to (or copies of) some or all of the information in my medical records, I will be given written notification of such denial. Otherwise, I will receive copies of my requested information or be notified of when I may review such information within 30 days of this request (or within 60 days if some or all of the information is stored at a location other than the Practice's office).

______________________________________ ____________________________
Signature of Patient or Personal Representative Date

If signed by a Personal Representative, please state your authority to act for the Patient:______________________
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FOR USE BY PRACTICE ONLY. **DATE RECEIVED:**

NAME OF PERSON REVIEWING REQUEST: DATE:

REQUEST GRANTED OR DENIED:

DATE COPIES SENT OR DENIAL LETTER SENT: PERSON SENDING COPIES OR DENIAL: Lisa Watson