EYE CARE *Specialists*, L.L.C.

Request For Access To Medical Information

Cape Girardeau, MO 63703
360 S. Mount Auburn Rd.
(p) 573-335-3577 | (f) 573-335-1559

Cape Girardeau Doctors' Park
64 Doctors' Park
(p) 573-334-5265 | (f) 573-334-3648

Poplar Bluff, MO 63901
579 Physicians Park Dr.
(p) 573-686-5579 | (f) 573-686-9555

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains describes your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them and/or limit/restrict health care information released. EYE CARE *Specialists*, L.L.C. and your authorized provider designated below will provide you a copy of this Notice of Privacy Practices upon request. **The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

Patient Name:		Date of Request:	
Social Security #:		Date of Birth:	

I hereby authorize _____ _____
(Name) *(Phone)*

_____ _____
(Address) *(Fax)*

to release to:

- ☐ EYECARE *Specialists*, L.L.C.
- ☐ David J. Westrich, MD, FACS
- ☐ D. Shawn Parker, MD, FACS
- ☐ Brad Stuckenschneider, MD, FACS
- ☐ Todd J. Lumsden, DO, FAOCO
- ☐ John R. Kinder, MD, FACS
- ☐ Richard L. Kies, MD, FACS
- ☐ Tatyana I. Metelitsina, M.D.
- ☐ T. Kim Krummenacher, MD
- ☐ Byron A. Santos, MD
- ☐ Michael J. Katich, OD

☐ Any and All Medical Information

☐ Restricted Health Care Information. Please provide dates, diagnosis, treatment, or any other indications of the specific information you desire:

contained in the medical record of _____ during my medical care at your facility.

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

Unless revoked, this authorization will expire on the following date or event _____ or one year from date of signature, unless otherwise specified. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that once information is released to the above-named person or persons, my information may be subject to re-disclosure. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

This Request was signed by: _____
Patient's Signature (or Representative)

Relationship to Patient (if other than patient): _____ Date of Birth: _____

Email Form