Massachusetts Eye Associates, P.C.

Request to Access Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 establishes an individual's right to access and receive copies of their protected health information (PHI). Massachusetts Eye Associates, P.C. requires that all requests for access and copies be made in writing using this form. Massachusetts Eye Associates, P.C.'s privacy officer will review all requests. Massachusetts Eye Associates, P.C. has thirty days to respond to your request. The practice can obtain an additional thirty days to complete this request with prior notice to you. This may be requested in cases where your information may not be active and is stored off-site in archives.

Date:______________________

Patient Name:___________________________________ DOB:____/____/____

Address:____

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I hereby authorize:_______________________________________ M.D./O.D.

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To release my records to Dr:_____________________________________

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Reason for request:____

Patient Signature (or authorized individual):____________________________________

If authorized individual, relationship to patient:_________________________________

<u>For practice use only</u>

MASSACHUSETTS EYE ASSOCIATES, P.C.

Privacy Officer Signature:____

Date of review:__________________

Comments:____

Return this completed form to:

Massachusetts Eye Associates, P.C.
19 Village Square
Chelmsford, MA 01824
Attn: Stacey Marston