Adamstown Eye Care, LLC

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Medical Record Transfer Request

Date: _____/_____/_____

To Whom It May Concern:

I, _____, authorize you to transfer a complete copy of my
(print patient's name)

medical record ***TO*** the following party as follows:

To Adamstown Eye Care, LLC, at the address, fax or email listed above,

as indicated by my initials here: _____

To the Party I indicate here: _____,

at the address, fax or email, I indicate here: _____

Privacy Notice and Agreement of Responsibility: This is a single medical record transfer request made by the patient or a legal representative of the patient permitting the disclosure of Protected Health Information (PHI) between two parties. This request remains in effect until the transfer is complete or the patient or a legal representative of the patient withdraws the request in writing. A separate request must be completed for each alternate or repeat transfer. By submitting this request, the patient or a legal representative of the patient agrees to accept full responsibility for accurately indicating the parties whom are permitted to share the PHI and full responsibility for accurately indicating the method of its secure transfer and agrees to hold harmless all those charged to satisfy this request as indicated. Anyone that requests a medical record transfer must be able to verify their identity and their relationship to the patient.

Signed: _____ Date: _____/_____/_____
(patient or legal representative)

Patient Date of Birth: _____/_____/_____ Patient Phone: (_____)_____

Patient Address: _____

Office Use Only: Medical Record Delivered by: _____ Date: _____/_____/_____