Mullis Eye Institute
1600 Jenks Avenue, Panama City, FL 32405
Ph. 850-763-6666 Fax 850-763-6665

Request for Release of Records

As a patient of Mullis Eye Institute, you are entitled under federal law to access your personal protected health information maintained in a "designated record set." In order to process your request for access to this information, please complete this form and submit it to the Privacy Officer. When received by the practice, we will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the practice office manager at 850-763-6666.

Patient Name: _____ Date of Birth: _____

Patient Number: _____ Date of request: _____

Access Method:
You have the right to view your protected health information, obtain a copy of the information, or both. Please indicate below whether you wish to view the information only, obtain a copy, or both. If you select "copy", please indicate your method of delivery.

☐ **I would like to view my protected health information. I will schedule an appointment to view my health information on _____. I understand Mullis Eye Institute may have a staff member sit down with me as I review my health information.**

☐ **I would like Mullis Eye Institute to provide to me an explanation or summary of the information provided. I understand that Mullis Eye Institute will charge me a fee of $15 for the explanation or summary and I will be required to pay the fee in full before I can obtain the explanation or summary.**

☐ **I would like a copy of my protected health information. I understand that Mullis Eye Institute will charge me a fee for the copies as set forth in the following schedule: $5 minimum, $1 per page. I also understand that I will be required to pay the fee in full before I can obtain the copy.**

I have selected the delivery method below:

☐ **I will return to pick up my copy when it is ready.**

☐ **I would like Mullis Eye Institute to mail the copy to:**

(Name)_____

(Street Adr)_____

_____

(City/State/Zip)_____

(Contact #)_____

Which shall include ☐ Complete medical record or ☐ other _____

I understand that Mullis Eye Institute is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site and that Mullis Eye Institute may extend the deadline by an additional thirty days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

By signing below, I acknowledge and agree to the above conditions.

_____ _____ _____

Patient Signature **Date** **Witness**