For office use only:
Account #: _____

CEI VISION PARTNERS

Request for Access to Medical Information/Records Release

The Notice of Privacy Practices (Notice) for CVP provides information about use of the patient's Protected Health Information (PHI). The notice also describes patient rights under the law. Patients have the right to access, inspect, and copy PHI used to make decisions about them. CVP provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

CVP may limit access to information generated only from CVP. Under some circumstances, such as increased risk of harm or injury, CVP may withhold the requested information. The Privacy Officer of CVP will evaluate this request and notify the patient of the decision within 15 days of this request. If the request is approved, CVP will provide the information within 30 days or within 60 days if such an extension is necessary. Reasonable costs may be charged for the request, and costs will be submitted to the patient upon approval of the request. If the patient is agreeable, CVP may provide a summary of the requested information.

Patient Name: _____ Social Security #: _____
Date of Birth: _____ CVP Physician: _____

Section A:
Healthcare information requested.

☐ Dates of Treatment or Particular Illness: _____
☐ All Records
☐ Other (please specify): _____

Is a summary of the information acceptable? ☐ Yes ☐ No
Reason for records release: _____

Section B:
Do you wish to:

☐ Arrange an appointment to inspect the requested information? (If checked, please contact Privacy Officer)
☐ Send the information to a non-CVP Doctor?
  ☐ Copies forwarded as directed by: _____ _____
  Staff Name Date
☐ Receive a copy of the information?
  ☐ Copies forwarded as directed by: _____ _____
  Staff Name Date

Information to be released:
☐ From ☐ To

_____
Name of Individual / Title

_____
Street Address

_____
City State Zip Code

_____
Phone Fax

☐ From ☐ To

Medical Records Department
1945 CEI Drive
Cincinnati, OH 45242
(513) 984-5133
Fax: (513) 984-4240

Unless otherwise revoked, this Authorization will expire one (1) year from the date it is signed, or if specified on the following date: _____. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosers occurring prior to our receipt of your revocation request. In order to revoke the Authorization the individual must submit a revocation request in writing to the Medical Records Department. I the undersigned herby authorize CVP to use and/or disclose medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

_____ _____
Signature of Patient or Representative Date
☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian

☐ Original to Privacy Officer ***(Section B Only)***
☐ Copy to Chart
☐ Copy to CVP Physician