



Request to Transfer Medical Records

I hereby authorize _____ (*health care provider*) to furnish copies of the medical record of _____ (*patient name with date of birth*) to the following doctor at Carmel Mountain Vision Care:

- | | |
|---|---|
| <input type="checkbox"/> Joel L. Cook, O.D. | <input type="checkbox"/> Barbara Bytomski, O.D. |
| <input type="checkbox"/> Kevin Reeder, O.D. | <input type="checkbox"/> Brian Chou, O.D., F.A.A.O. |
| | <input type="checkbox"/> Earl Sandler, O.D. |

Please provide:

- The portion of the records concerning _____
- The entire medical record

I understand that California state law (Health & Safety Code §123110) allows you to charge me up to \$0.25 per page or \$0.50 per page for copies from microfilm, plus any additional reasonable clerical costs incurred in making the records available. All reasonable costs, not exceeding actual costs, incurred in making copies of x-rays, or tracings derived from electrocardiography, electroencephalography or electromyography, may also be charged to me.

- I agree to any charges as specified above. Please bill me at _____ (*address*)

- Please let me know how much this will cost by first calling me at (_____) _____ (*phone number*)

Printed Name of Requestor (*Patient or Minor's Parent/Guardian*) _____

Signature of Requestor _____ Date _____

Notice to Health Care Provider:

California state law (Health & Safety Code §123110) requires the transmission of the requested information within fifteen days of receiving this request. It is illegal to discriminate against types of health care providers when sending out medical records requested under the Patient Access to Medical Records law. Records should be sent to the following address (or alternatively faxed to 858-484-9143):

Carmel Mountain Vision Care
9320 Carmel Mountain Road, Suite E
San Diego, CA 92129