NEW PATH VISION

PERSONALIZED EYE CARE | POTTSTOWN, PENNSYLVANIA

1100 Heritage Drive, Pottstown, PA 19464

610-326-2754 | office@newpathvision.com

Patient Request for Copy of Medical Records

Use this form to request access to your own New Path Vision records.

PATIENT INFORMATION

Patient name

Date of birth

Phone

Mailing address

RECORDS REQUESTED

- ☐ Complete eye-care record
- ☐ Most recent exam
- ☐ Prescriptions
- ☐ Diagnostic test results / images
- ☐ Billing / insurance records
- ☐ Operative / co-management records
- ☐ Other

Date range

Other / details

PREFERRED FORMAT

- ☐ Paper copy
- ☐ Electronic copy, if available in an agreed format
- ☐ Inspect in person

PREFERRED DELIVERY

- ☐ Mail paper copy to the address above
- ☐ Pick up from New Path Vision
- ☐ Other mutually agreed delivery method (contact the practice)

Important delivery information

New Path Vision does not routinely send medical records through ordinary email. If you request an electronic copy, contact the practice so an available format and delivery method can be discussed. Completed records requests should not be sent through the general website contact form.

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Fees, processing and patient authorization

PAPER-COPY FEE

Paper copies may incur a reasonable, cost-based copying and printing charge as permitted by applicable law. If a charge applies, New Path Vision will provide an approximate fee before the copy is produced. Postage may also be charged when you ask for records to be mailed.

TIMING AND PROCESSING

New Path Vision will process access requests in accordance with applicable law. The practice may contact you to verify identity, clarify the scope of the request, confirm the requested format, or arrange an appropriate delivery method. A request will not be denied solely because a permitted copying fee has not yet been paid; the practice will explain any applicable fee and next steps.

PATIENT CERTIFICATION

I am requesting access to the records identified on this form. I understand that New Path Vision may contact me to verify my identity or clarify the request. I understand that paper copies may involve a reasonable, cost-based copying charge and postage when applicable.

Patient / Authorized Representative Signature

Date

Printed name

Authority if signing for patient

How to submit

Bring the completed form to New Path Vision or contact the practice at 610-326-2754 for submission instructions. Do not send a completed records-request form or protected health information through the general website contact form.