

ACCESS TO MEDICAL RECORD

IN AN EFFORT TO BE COMPLIANT WITH HIPPA INDIVIDUAL ACCESS TO HEALTH RECORD, OUR PRACTICE OFFERS ELECTRONIC STORAGE OF YOUR MEDICAL RECORD THROUGH A SECURED ONLINE PORTAL. YOU MAY ACCESS YOUR PORTAL ANYTIME AND ANYWHERE, SIMPLY BY PROVIDING US WITH AN EMAIL ADDRESS. IF THERE IS NO EMAIL, WE WILL PROVIDE YOU WITH A GENERIC USERNAME AND PASSWORD AT CHECK-IN.

Website of Patient Portal

<https://allianceretinatx.ema.md/ema/PatientLogin.action>

ANY PATIENT OR THIRD-PARTY REQUEST FOR PAPER OR PORTABLE ELECTRONIC STORAGE OF MEDICAL RECORD WILL BE SUBJECTED TO A REASONABLE, COST-BASED FEE. (Based on Texas Title 22 Part 9 Chapter 165 Rule 165.2)

ANY THIRD-PARTY REQUEST FOR PAPER OR PORTABLE ELECTRONIC MEDICAL RECORD WILL BE SUBJECTED TO THE AVAILABILITY OF A WRITTEN CONSENT AT THE TIME OF THE REQUEST.

Paper Copy:

\$25.00 for the first 20 pages; then, \$0.50 per page for every copy thereafter. In addition, actual cost of mailing or shipping.

Electronic:

\$25.00 for 500 pages or less (email, fax,...)

\$50 for more than 500 pages (email, fax....)



BOARD-CERTIFIED IN OPHTHALMOLOGY
VITREORETINAL SURGERY & DISEASES

FMLA/Short-Term or Long-Term Disability/Work-related claims/Executing Affidavit

\$25.00 for executing affidavit (letter from a doctor) of less than 2 pages

\$50.00 for any paperwork of more than 2 pages

No Charge:

1. Notes to another medical office that is listed as Patient's Referring Provider or Primary Care Physician or those listed under Patient Care Team at the time last services were rendered.
2. Transfer of care due to relocation or out-of-network insurance (limited to first & last office visit note & operative report. Any other request is subjected to a fee as above).
3. Doctor referral notes (Alliance Retina is referring the patient out to another physician)
4. Notes requested by patient's medical insurance policy or worker comp policy to support the medical claims

THOUGH WE DO OUR BEST TO ENSURE TIMELY REVIEW AND PROCESSING OF YOUR MEDICAL RECORD REQUEST, THE ACTUAL COMPLETION IS SUBJECTED TO AVAILABLE STAFFING AND CURRENT RESOURCES.

By signing this form, I acknowledge I have read Alliance Retina Medical Record Policy disclosure and understand all of its content. I understand that I may ask any questions before signing the disclosure. I also may request for a signed copy of this written notice at any time.

Name & Sign: _____

Date: _____