Transfer of Medical Records From: ____

I request the transfer of the medical record for the following named patient, in whole or in part, as indicated below.

Patient Name: ____

Patient Address: ____

____

Patient Date of Birth: ____

Please send this information to:
Rebecca Sparks, OD
Sparks Eye Care LLC
307 W Highway 54, Ste 100
Andover, KS 67002
Phone: 316-201-1837
Fax: 316-239-6014

Records to include (check as appropriate):

___ Entirety of medical record

___ Medical record between dates as specified (inclusive)
_________________ to _________________

Terms and Conditions:

- I have the right to revoke this Authorization, in writing, at any time by notifying the Privacy Office at Sparks Eye Care and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that already had been disclosed in reliance on this Authorization.
- I have the right to not sign this Authorization. Dr. Sparks will not condition treatments, payment for services or enrollment or eligibility for benefits on whether I sign this Authorization.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
- I have read and understand this Authorization, have had an opportunity to have my questions answered, and have signed this Authorization freely.
- This Authorization expires one (1) year after the date of signature unless others specified: ____________________________

Signature: ____

Print Name: ____

Relationship to patient: ____________________________
(Parent or Guardian, if applicable)

Date: __________________