KINDERMANN EYE ASSOCIATES
3001 Chapel Avenue, Suite 200, Cherry Hill, New Jersey 08002 (856) 667-3937

Request for Medical Records

Dear Dr. _____(doctor sending records)

I request that my medical records, which may contain personally identifiable information, be forwarded to the address below. I understand that pursuant to the Health Insurance Portability Accountability Act of 1996, I must request specific dates of service or incidents of care, blanket releases will not be accepted.

Dates requested: _____

Incident of care requested _____

Kindermann Eye Associates
3001 Chapel Avenue, Suite 200
Cherry Hill, New Jersey 08002
Phone: (856) 667-3937 FAX: (856) 667-0661

_____

Authorized Signature **Date**

_____

Patients Signature **Date**

_____

Please print patient's name **Date of Birth**

_____

Patients Social Security Number