Records Transfer Request

Sacopee Valley Eye Care
91 Maple St.
P.O. Box 18
Cornish, ME 04020
207-625-3700

Request Records From/ Send To (Circle one):
Doctor or Organization: _____
Address: _____
Fax: _____

Patient Name: _____
Date of Birth: _____
Patient Phone number: _____

I authorize a release of Protected Health Information (PHI) and request the following records be transferred:

_____ Last Exam
_____ Complete Record
_____ Prescription

Transfer records to:

_____ Mail or Fax #:
Send to: _____
_____

_____ Sacopee Valley Eye Care
Mail to: Address listed above
_____ Sacopee Valley Eye Care
Fax to: 207-625-3277

This signed authorization will be effective until _____ or no longer than 12 months from the date signed. If at any time before the ineffective date I wish to revoke this authorization, I can submit in writing to Sacopee Valley Eye Care my signed revocation.

_____ _____
Patient's Signature Date