Wisda Eye Center

Ophthalmology and Ophthalmic Surgery

Main Road Commons • 1318 South Mail Road
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Catherine L. Wisda, M.D.
Board Certified

PATIENT MEDICAL RECORDS REQUEST FORM

(Please Print)

Date: _____

Patient Name: _____

Patient Address: _____

_____

_____

DOB: _____

I hereby request a copy of my medical records be RELEASED FROM:

_____

_____

_____

PLEASE FORWARD MEDICAL RECORDS TO:

_____

_____

_____

Patient Signature: _____
Print name: _____
Date: _____

Witness of Patient Signature: _____
Print name: _____

C: Patient file

Revised form: 1/2017

WISDA EYE CENTER, PC

APPROVAL FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION-(PHI)

The HIPAA Privacy Law enacted in 2001 ensures your protected privacy of your Ophthalmologic medical condition. Our office and doctor's need to know how we may reach you with results of tests and with whom we may discuss your medical eye condition.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply):

Home Telephone _____

◊ You may leave message with detailed information.

◊ You may leave message with call back number only.

Work Telephone _____

◊ You may leave message with detailed information.

◊ You may leave message with call back number only.

Cell Telephone _____

◊ You may leave message with detailed information.

◊ You may leave message with call back number only.

Written Communication

◊ O.K. to mail to my home address

◊ O.K. to mail to my work/office address:
_____

◊ O.K. to fax to this number:
_____

Oral Communication (check all that apply)

◊ O.K. to release PHI to my significant other. (Name) _____

◊ O.K. to release PHI to the following family members: (Names/Relationship)
_____
_____

◊ O.K. to leave detailed message on answering machine.

◊ O.K. to release PHI to anyone else I listed below:
_____

_____
(Patient Signature)

_____
(Date)

_____
(Print Name)

_____
(Witness)