



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

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.

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:

Work Telephone _____

- ◇ You may leave message with detailed information.
- ◇ You may leave message with call back number only.

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:

Cell Telephone _____

- ◇ You may leave message with detailed information.
- ◇ You may leave message with call back number only.

(Patient Signature)

(Print Name)

(Date)

(Witness)