Ophthalmology Associates, S.C.

Patient Request to Access Protected Health Information

I, _____, date of birth,____/____/_____authorize Ophthalmology Associates, S.C. to provide me with access to my personal health information as indicated below.

☐ All Medical Records generated through Ophthalmology Associates, S.C.

or

☐ Medical Records from only the following dates

From:_____ To:_____

☐ Billing Records

The records would include the following, but are not limited to: exam notes, history notes, hospital reports, lab results, diagnostic test results, reports from outside procedures, available notes from previous doctors, interpretations of photos/slides, contact lens records.

If we are in possession, we will not disclose any medical records generated from other health care providers prior to your initial visit with Ophthalmology Associates, S.C.

I request access to my health information through:

☐ **Copies** of the requested information to:

☐ Myself ☐ Doctor's Office ☐ Other_____

Name:_____

Address:_____

City/State/Zip code:_____

Please indicate below how you would like the records processed:

☐ Mail ☐ Fax ☐ PickUp at: **(circle one)** ***Layton Cudahy HalesCorners New Berlin*** ☐ Someone else to pick up

If you have an appointment with your new physician please indicate the date_____

I understand that Ophthalmology Associates, S.C. may charge a fee for the costs of copying, mailing and supplies associated with my request.

☐ **Inspection** of the requested information.

Please contact Katherine Missurelli at (414) 281-0424 to arrange for a mutually convenient time and location for inspection

☐ **A Summary of Explanation** of the requested information.

Ophthalmology Associates, S.C. will release your records in a reasonable time, but the privacy standard allows 30 days to process requests. We assure you we will release your records in as timely manner as possible.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____ _____

Representative's Name Representative's Authority

I hereby certify that the medical records attached are for: _____

Patient Name

Records certified ☐ *Katherine* ☐ *Debbie* ☐ *Dr.*_____