

**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

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    Pick Up at:   **(circle one)**   *Loomis*   *Cudahy*   *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     Becky     Dr. \_\_\_\_\_