Wyomissing Optometric Center

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Due to the **HIPAA Compliance Privacy Laws of the federal government,** it is mandatory that we ask you to review and answer the following questions:

Name: _____ Home Phone: _____ Cell: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

Home: Yes _____ No _____ Cell: Yes _____ No _____

May we contact you at work? Yes _____ No _____ Work Phone # _____

May we leave a message for you at work? Yes _____ No _____

Do you authorize us to discuss your personal health information with any particular person (family or otherwise)?

This could include general, imaging or billing information: Yes _____ No _____

If yes, please list the persons you authorize to receive this information:

Name _____ Relationship _____ Phone #_____

Name _____ Relationship _____ Phone #_____

Name _____ Relationship _____ Phone #_____

I hereby authorize Wyomissing Optometric Center physicians and staff to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from any other health care providers, laboratories, imaging facilities, or other institutions.

This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all issues as stated above. I have reviewed the Wyomissing Optometric Center HIPAA PRIVACY POLICY. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

If not signed by patient, relationship to patient: _____