WILLIAMS AND WITHERELL
Customized Cataract Surgery
OPHTHALMIC SURGICAL ASSOCIATES, INC.

(610) 874-5261
Ophthalmic Surgical Associates, Inc.

PATIENT DISCLOSURE AUTHORIZATION (HIPAA)

With your permission, we can provide information to you in a variety of ways. Please indicate agreement with the following by checking all that apply:

Date: _____

Patient Name: _____ _____
Printed Signature

☐ It is acceptable for you to leave information on my answering machine, including appointment reminders.

*Phone Number: _____

☐ I do not want you to speak with any family members or friends regarding my condition.

☐ It is acceptable for you to speak with only the following family members/friends regarding my condition: *(please check all that apply)*:

☐ Spouse Name: _____
Phone #: _____

☐ Sibling Name: _____
Phone #: _____

☐ Children Name: _____
Phone #: _____

☐ Friend Name: _____
Phone #: _____

☐ Other Name: _____
Phone #: _____

Any additional persons, please list on back of form.

It is the patient's responsibility to notify the office staff of any changes to this Authorization.

Photo ID Verified. Date: _____ By:_____