AUTHORIZATION for RELEASE of HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ ID Number: _____

Person/Organization **providing** the information**:**

New Eyes
2020 Wellness Way, Suite 402
Las Vegas, NV 89106

Person/Organization **receiving** the information:
(Please include name, address, phone and fax #)

_____

_____

Phone: _____ Fax: _____

Describe the information to be released or check specific data below. Please check from which doctor and include dates of service and type of service:

☐ Dr. Pizio ☐ Dr. Austin ☐ Dr. Waite ☐ Dr. Hiss ☐ Dr. Hartman ☐ Dr. Stafeeva ☐ All doctors

☐ All treatments/clinical records ☐ Clinical records for dates of service: From _____ To _____

☐ Photos ☐ Visual Field Test ☐ OCT ☐Topography

(There may be additional fee for re-printing photos or to have tests printed in color)

Describe the purpose of this request:

☐ Moving or re-location purposes ☐ Copies for PCP ☐ For Personal Records ☐ Health Insurance

☐ Transferring Care to another Eye Doctor

☐ Other: _____

(*Initial all)*

_____ I understand that medical records described above may include sensitive information related to Workman's Comp, HIV/AIDS infection, psychological diagnosis and treatment or drug and alcohol abuse information.

_____ This authorization shall become effective immediately and will expire on the following date, event, condition or in six months from date signed _____.

_____ I understand that I will receive a copy of this form after I sign it. I may see and request a copy of the information described on this form if I ask for it**. <u>I agree to pay any fees associated with copying of records according to NRS 629.061.</u>** I also understand that any review of original medical records will be supervised.

_____ I understand I have the right to revoke this authorization, in writing received at the address below. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ I understand that the authorized health information may be electronically communicated.

_____ _____

Signature of patient *or* patient's legal representative **Date**

Printed name of patient's legal representative: _____

Relationship to the patient: _____

Witness signature: _____ Date_____

For office use only: Employee receiving request at New Eyes: _____ Date received: _____

Fee sheet to be prepared and given to patient or person requesting the records.