AUTHORIZATION for RELEASE of HEALTH INFORMATION

Patient Name: __________________________________ Date of Birth: ____________ ID Number: __________

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

New Eyes
2020 Goldring Ave, Suite 402
Las Vegas, NV 89106

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

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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**. I agree to pay any fees associated with copying of records according to NRS 629.061.** 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.