

# AUTHORIZATION for RELEASE of HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ ID Number: \_\_\_\_\_

Person/Organization **providing** the information:

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

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

\_\_\_\_\_  
\_\_\_\_\_  
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. Stafeeva  Dr. Fajardo  Dr. Smart  Dr. Austin  Dr. Kwong  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.