Patient Authorization for Use and Disclosure of Protected Health Information

By signing this release, I authorize:

_____

_____

Phone: _____

Fax: _____

To release my Protected Health Information to:

Nevada Eye Physicians
1505 Wigwam Pkwy Ste. 100
Henderson NV 89074
Phone:(702)896-6043
Fax:(702)896-9591

This authorization permits you to disclose the following individually identifiable health information me (specifically describe the information to be used or disclosed, such as dates(s) of services, type of services, level of detail to be released, and origin of information etc.):

_____

_____

_____

The information will be used or disclosed for the following purpose:

_____

_____

_____

(If requested by the patient, purpose may be listed as "at the request of the individual")
The purpose(s) is /are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one year from the execution date below.

The practice will_____ will not_____ receive payment or other remuneration from a third party in exchange for using or disclosing PHI.

I do not have to sign this authorization in order to receive treatment from Nevada Eye Physicians. In fact have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

_____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

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_____ _____ _____

Patient's Name | Date of Birth | Social Security Number

_____ _____

Print Name of Patient of Legal Guardian | Date

Patient/Guardian to be provided with a signed copy of authorization
Please fax completed forms to: (702)896-9591