

**AUTHORIZATION
For Release of
PROTECTED HEALTH INFORMATION**

**Main Office: Shepherd Eye Center, 3575 Pecos McLeod, LV NV 89121
Telephone: 702-731-2088 FAX: 702-734-7836**

This Authorization authorizes the release of Protected Health Information. The undersigned authorizes the above-named "Provider" to release the information noted above. By signing below, I acknowledge:

- (i) that I have the right to revoke the authorization at any time;
- (ii) that once the information is disclosed, federal privacy law may no longer protect it;
- (iii) that I may only revoke this authorization in writing by mailing to the Privacy Officer by certified mail.
- (iv) that I further understand that my treatment by the Provider is not contingent on my signing this authorization.
- (v) This authorization will remain in effect for one year unless otherwise specified here: _____

Shepherd Eye Center does not charge for copies of your records for the last two visits or visits covering the span of the last 12 months, which ever contains more medical information. Copy charge for other remaining protected health information is copied at .12 per page.

Thank you for your cooperation.

Where would you like us to get your records from?

Name _____
Address _____
City _____ State _____ Zip _____
Telephone _____ Fax _____

Where would you like us to send your records?

Name _____
Address _____
City _____ State _____ Zip _____
Telephone _____ Fax _____

For the purpose of continued care, please specify which records we will send or receive.

Dates _____ / _____ All Records _____

How are records to be released?

Mail Fax Call patient when ready for pickup at: Pecos Summerlin Green Valley

Patient Name: _____

Date of Birth: _____ **Social Security #:** _____

Patient Signature: _____ **Date:** _____

If person signing is other than patient, state authority under which signature is made: _____