Authorization for Release Of Protected Health Information

Please Note 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 that I have the right to revoke the authorization at any time that once the information is disclosed, federal privacy may no longer protect it, that I may only revoke this authorization in writing by mailing to the privacy officer by certified mail. That I further understand that my treatment by the provider is not contingent on my signing this authorization Note this authorization does not extend to HIV results, mental health records, drug or alcohol treatment records that are not protected by federal law. **Shepherd Eye Center does not charge for personal copies of the *last two* clinical visits. Copy charge for the other remaining visit notes will be a charge of $0.60 per page. For any questions, please call 702-731-2088, EXT: 2084. Thank you.**

Patient's Name: ____

Date of Birth:____

PatientPhone#:____

By signing this release, I authorize Shepherd Eye Center to Obtain or Release my protected health to/ from:

FacilityName:____

PhoneNumber:____

Faxnumber:____

Address:____

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

Dates Requested:

From____/___/_____ To:___/____/_____

Types of services Requested: (Please check one or both boxes)

Patient Chart Notes: ( ) Patient Testing: ( )

Any other Services requested please specify here:____

How are the records to be released:

Mail: ( ) Fax: ( ) Pick up: ( )

Please Specify which location Records will be Picked up:____

Patients Signature:____ Date:_____/_______/______

Medical Records fax # (702) 734-7836 **Medical Records Address: 3575 Pecos-Mcleod Interconnect Las Vegas, NV 89121**