# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Medical Records Address: 3575 Pecos McLeod Interconnect, Las Vegas, NV 89121
Ph (702) 731-2088, option 2 Fax (702) 734-7836

**Patient's Name**: _____ **Date Of Birth**: _____

**Patient Phone#**:_____

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

**Facility Name**: _____

**Address:** _____

**Phone Number**: _____ **Fax Number**: _____

**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 for pick up: _____

**Authorization re: sensitive information: To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do NOT permit information of this type, if it exists, to be released. I understand that if I do not check the box, such information about me will be released if it exists.**

☐ **HIV/AIDS** ☐ **Genetic Information** ☐ **Treatment for alcohol and/or drug abuse**

☐ **Mental Health** ☐ **Psychotherapy Notes** ☐ **Sexually Transmitted Diseases**

**Without my express revocation, I understand that this authorization will expire in one (1) year from the date signed unless indicated below:**

- ☐ **Under the following condition(s):_____**
- ☐ **Upon satisfaction of the need for disclosure**
- ☐ **On_____(*enter a future date other than date signed by patient not to exceed 1 year)***

**I understand that once my medical records leave this practice, there is a potential for redisclosure by the recipient if they are no longer protected by the Privacy Rule.**

**I may revoke this authorization in writing, but any previously disclosed information would not be subject to such revocation. I may inspect or copy the information to be used or disclosed and may refuse to sign the authorization. My refusal to sign will not affect my ability to obtain treatment, payment, enrollment or my eligibility for benefits, unless otherwise described in the space provided here: _____**

**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**

**Patients Signature:**_____ **Date:**_____/_____/_____