RETINA CONSULTANTS OF NEVADA
Diseases and Surgery of the Retina and Vitreous

Patient-Appointed Designate Authentication & Authorization Form

According to HIPAA and as our patient, you are entitled to privacy of your ***protected health information*** **(PHI)**. We are required to offer you the option to appoint a person of your choice who Retina Consultants of Nevada may disclose your PHI to on your behalf. This designate would be someone who would accompany you to the office; someone who the Retina Consultants of Nevada's healthcare team may call to relate information about you to; someone who would call in for information regarding your care and treatment. You have the right to revoke or change your choice of designate in writing, except to the extent that action has already been taken in reliance on this authorization, or if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Retina Consultants of Nevada must receive the revocation in writing. Retina Consultants of Nevada will accept written revocation of this authorization to the Privacy Officer, via CERTIFIED MAIL; and said revocation will not be in effect until received by said Privacy Officer.

Patient Name: ____

Date	**Designate Name**	**Designate Date of Birth**	**Designate Social Security #** Last 4 Digits	**Designate Picture ID** Verified	**Expiration Date** 12/31 of Present Year
________	____________________	__________	__________	________	__________

Patient Signature:______________________ Date: ______________

Revocation Effective: ______________
FOR OFFICE USE ONLY

Date	**Designate Name**	**Designate Date of Birth**	**Designate Social Security #** Last 4 Digits	**Designate Picture ID** Verified	**Expiration Date** 12/31 of Present Year
________	____________________	__________	__________	________	__________

Patient Signature:______________________ Date: ______________

Revocation Effective: ______________
FOR OFFICE USE ONLY

Date	**Designate Name**	**Designate Date of Birth**	**Designate Social Security #** Last 4 Digits	**Designate Picture ID** Verified	**Expiration Date** 12/31 of Present Year
________	____________________	__________	__________	________	__________

Patient Signature:______________________ Date: ______________

Revocation Effective: ______________
FOR OFFICE USE ONLY