



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 MAIL; and said revocation will not be in effect until received by said Privacy Owner.

Patient Name: _____

Date _____ **Designate Name** _____ **Designate Date of Birth** _____

Patient Signature: _____ Date: _____

Revocation Effective: _____
FOR OFFICE USE ONLY

Date _____ **Designate Name** _____ **Designate Date of Birth** _____

Patient Signature: _____ Date: _____

Revocation Effective: _____
FOR OFFICE USE ONLY

Date _____ **Designate Name** _____ **Designate Date of Birth** _____

Patient Signature: _____ Date: _____

Revocation Effective: _____
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