Authorization For Release of Protected Health Information

Patient's Name: ______________________________

DOB: ______________________________

Phone Number: ______________________________

By signing this release, I authorize Retina Consultants of Nevada to obtain or release my protected health information to/ from:

Name/ Facility: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

Address: ______________________________

☐ Requesting medical records for the last year starting from last office visit.
☐ Specific dates request from ________________ to ________________

How are the records to be released: Certified Mail ☐ Fax ☐ Pick up ☐

Please specify which location records will be picked up: ________________

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.

In accordance with policy, it takes approximately ten (10) working days to process a PHI request. **Retina Consultants of Nevada does not charge for copies of the most recent clinical notes. The fee for all other record requests will be sixty (60¢) cents per page except colored photos taken, which are ten ($10.00) dollars per date of service.**

Patient's Signature: ______________________ **Date:** ________________

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