Authorization For Release of Protected Health Information (PHI)

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*** OR ☐ ***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: **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 one ($1.00) dollar per page.**

Patient's Signature: _____ **Date:** _____

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