Authorization For Release of PHI From Other Source

I, __________________________________, specifically authorize any current employee or owner of
(Please Print Your Name)

____
Name(s) or Class of Person(s)

____
Address, City, State, Zip

____
Phone Number Fax Number

To release or disclose my protected health information ONLY to:

Retina Consultants of Nevada
653 N Town Center Drive - Suite 518
Las Vegas, NV 89144
702-369-0200
702-369-4143 (Fax)

Any disclosure of my protected health information to a **different** name, class of person, address or fax number will require a separate authorization.

I have the right to revoke this authorization 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, the above name(s) or class of person(s) must receive the revocation in writing.

This authorization shall expire one year from the date signed or on the following date: __________. After one year or this date (which ever comes sooner), the above name(s) or class of person(s) can no longer use or disclose my protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

____ ____________________________
Patient Signature **Date of Birth**

____ ____________________________
Social Security Number **Date of Request**

____ ____________________________
Request Processed By **Date**

____ ____________________________
Completed By **Date Mailed/Faxed (Circle One)**