Authorization Form for Records Release

Practice/Doctor's Name:	**In Focus Eye Care Center**
Mailing Address:	**8660 W. Cheyenne Ave. Suite 120** **Las Vegas, NV 89129**
Phone Number:	**702-790-2440**
Fax Number:	**702-790-2441**

Authorization for Release of Identifying Health Information

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

The Professional office named above is authorized to release health information identifying

_____**under the following terms and conditions:**

1. What to be released: _____

2. To whom the information will be released: _____

_____

_____

3. The purpose for the release: _____

4. Expiration date of event: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have on file, before deciding whether to sign this authorization. *Our Notice of Privacy Practices* explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office contact person, listed above, to initiate the process.

If you sign this authorization, you can revoke it later, except if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that you authorization is revoked. Send this note to the office contact person listed above.

When your health information is disclosed as provided in this authorization the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

We will not receive a financial benefit from disclosing this health information about you.

I have read and understand this form. I am signing voluntarily. I authorize the disclosure of my health information as described above.

_____ _____

Signature **Date**

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign the form:

_____ _____

Relationship to Patient **Print Name**