415 US Hwy 95a S Unit A, Fernley NV 89408
p (775)575-5700 f (775)575-5702

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____
Patient Address: _____
Patient Phone Number: _____ **Date of Birth:** _____
Doctor/Office to Release to: **revolutionEYES – Dr. Kristina Rhodes**
Doctor/Office to release from: _____

I authorize the office named above to release health information identifying me. I am aware that this information may include if applicable, information about substance abuse treatment, and information about mental health services. I agree to release this information under the following terms and conditions:

1. Detailed description of the information to be released
2. To whom the information may be released {i.e.: names or classes of recipients}
3. The purpose(s) for the release {if the authorization is initiated by the individual, it is permissible to state "at the request of the individual as the purpose"}
4. Expiration date or event relating to the individual or purpose for the release:

It is your decision whether or not to sign this authorization form. If you sign this authorization, you can revoke it later. The only exception to your right is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic letter telling us that your authorization is revoked to the office contact listed at the top of the form.

When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated: _____ Patient signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____ Print name: _____

Source of Authority: _____