Meadows Eye
Physicians & Surgeons

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

REQUEST TO RECEIVE RECORDS

I, date of birth

authorize to release all medical

records which might effect ongoing treatment of eye disease to:

Meadows Eye
5295 S Durango Dr, Suite 102
Las Vegas, NV 89113
(702) 358-0472 phone
(702) 425-9955 fax
info@meadowseye.com

I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I have the right to withdraw permission for the release of my information. I can revoke that authorization at any time athought this revocation must be made in writing and will not affect information that has already been used or disclosed. I have the right to receive a copy of this authorization. I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization. I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE AUTHORIZATION

SIGNATURE: DATE

PRINTED NAME: TIME