



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

REQUEST TO RECEIVE RECORDS

I _____ date of birth _____
authorize
to release all medical records and **previous testing (HVF, OCT, photos,etc.)** which might affect ongoing treatment of eye disease to:

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

REQUEST TO SEND RECORDS

I _____ date of birth _____ hereby authorize Meadows Eye to release all records to:

Name _____
Address _____
City, State , Zip _____
Phone/Fax _____

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 atought 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

REQUEST TO RELEASE MEDICAL RECORDS VIA EMAIL

I _____ date of birth _____

authorize Meadows Eye to send my medical records electronically to the following email address:

Designated Email Address: _____

Confirm Email Address: _____

Acknowledgment of Email Security Risks

I understand that standard, unencrypted email may not be secure and that medical records sent by email could potentially be accessed, intercepted, or disclosed to unauthorized individuals. I acknowledge these risks and expressly request that Meadows Eye transmit my medical records to the email address provided above, even if the email is not encrypted. I understand that I am responsible for providing an accurate email address and maintaining the security of my email account.

By signing below, I confirm that I have been informed of the potential risks and voluntarily request the electronic transmission of my medical records via email.

SIGNATURE AUTHORIZATION

SIGNATURE: _____

DATE _____

PRINTED NAME: _____

TIME _____