Authorization Form

Dr. Ellen Merkin O.D.
2920 South Rainbow Boulevard, Suite 120
Las Vegas, Nevada 89146

Authorization of Release of Identifying Health Information

Patient Name: _____

Patient Phone Number: _____

Patient Address: _____

The professional office named above is authorized to release health information identifying _____(Patient Name) under the following terms and conditions:

1. **To whom the information will be released (i.e., the name of a family member):** _____
2. **Detailed description of the information to be released (i.e., complete medical records or prescriptions):** _____
3. **The purpose of the release (i.e., picking up glasses):** _____
4. **Expiration date or event (i.e., the date when this authorization expires):** _____

Signing this form is completely your decision. We cannot refuse to treat you if you choose not to sign this authorization. You can also review the health information 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 our office to initiate the process.

If you sign this authorization, you may revoke it later, unless we have already acted in reliance upon the authorization. If you wish to revoke your authorization, send our office a written or electronic note informing us that your prior authorization is revoked.

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 the health information you authorize us to disclose. **I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.**

_____ _____
Signature Date

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

_____ _____
Relationship to patient Print name

Receipt of Notice of Privacy Policies & Consent Form

Dr. Ellen Merkin O.D.
2920 South Rainbow Boulevard, Suite 120
Las Vegas, Nevada 89146

Patient Name: _____

Patient Phone Number: _____

Patient Address: _____

In the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and/or to conduct healthcare operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes the care and service provided here, but also disclosure of your health information may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment include: (1) our submission of your health information to a billing agent or vendor for processing claims to obtain payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of your benefits, and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy at our office.

When you sign this consent document, you signify that you agree to our use and disclosure of your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You also signify that you have received a copy of the ***Notice of Privacy Practices***.

I have read this document and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* of the office.

_____ _____
Signature Date

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

_____ _____
Relationship to patient Print name