CYNTHIA KIERNAN, O.D. & ASSOCIATES
AUTHORIZATION FORM
Patient Release of Protected Health Information

Mailing Address: 7732 Royal Oaks Road
Las Vegas, NV 89123
Telephone #: (702) 614-5435
Fax #: (702) 614-5426
Office Contact / HIPPA Officer: Tammy Hughes

PATIENT INFORMATION
Patient's Name: _____

Patient's Date of Birth: _____ Telephone #: _____

Patient's Address: _____

AUTHORIZATION
I authorize Cynthia Kiernan, O.D. & Associates and its business associates to use/disclose, or to receive Protected Health Information by the people, groups or organizations that are listed below: (attach a page if necessary)

Name: _____

Telephone #: _____ Fax #: _____

Address: _____

I authorize:
- ❑ The release of my Protected Health Information.
- ❑ The release of prescription: _____Glasses RX _____Contact Lens RX _____Fax RX to # above
- ❑ The release of previous records, i.e., old exams: _____
  _____
  - ❑ Please fax records to Cynthia Kiernan O.D., & Associates at (702) 614-5426.
- ❑ The use of my Protected Health Information for marketing products or services by mail, phone, or fax.
- ❑ Other: _____

REASON FOR REQUEST
You may check the box below that states "At patient's request" or you may specify below the reasons you are authorizing Cynthia Kiernan, O.D. & Associates to share your Protected Health Information.
- ❑ At patient's request.
- ❑ Other reasons (specify): _____

SIGNATURE
I understand that:
- This authorization is valid for one (1) year from the date of my signature.
- I have the right to cancel this Authorization at anytime by completing a hard copy of the Revocation of Authorization form, available from the Privacy Officer.
- If Cynthia Kiernan, O.D. & Associates has already released my health information (due to an earlier authorization), that information will be exempt from my revocation.
- If the person or entity that receives my health information is not required to comply with the federal privacy regulations, the information would no longer be Protected by those regulations.

I understand that my treatment is not contingent upon my signing this form. I understand that if I do not sign this form, the authorization would be invalid.

_____ _____
Patient's Signature *Date*

If you signed this form as a legally recognized representative of the patient, please print your name below and your relationship to the patient that allows you to act on their behalf by signing this form.

_____ _____
Representative/Relationship *Date*