ALOHA VISION CONSULTANTS

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Kelly Ann Koide, OD

Authorization for Disclosure of Protected Health Information

I _____ _____ _____
(Patient's Name – please print) **(Birth date)** **(Social security number)**

AUTHORIZE

_____
(NAME)

_____
(ADDRESS)

_____ _____
(CITY AND STATE) **(ZIP CODE)**

MY AUTHORIZATION APPLIES THE DISCLOSURE OF THE INFORMATION BELOW. ONLY THIS INFORMATION MAY BE USED/OR DISCLOSED PURSUANT TO THIS AUTHORIZATION. (check all that apply):

( ) MEDICAL RECORDS ( ) CLINICAL NOTES ( ) LAB RESULTS ( ) X-RAY RESULTS ( ) HIV TEST RESULTS

OTHER _____

I AUTHORIZE THE FOLLOWING PERSON TO MAKE AUTHORIZED USE OF MY PROTECTED HEALTH INFORMATION:

Dr. Kelly Ann Koide
1029 Kapahulu Ave Ste 502
Honolulu, HI 96816

I understand that, if my protected health information is disclosed to someone who is not required to comply with the Federal privacy protection regulations, then the information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this authorization at any time. My revocation MUST be in WRITING (e.g. letter). I am aware that my revocation is not effective to the extent that the persons I authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Jason T. Tokunaga, M.D., nor will it affect my eligibility for benefits.

My protected health information will be used or disclosed upon request for the following purposes (check as many as apply):

( ) Personal Records ( ) Continued Medical Care ( ) Legal Action ( ) Insurance Claim

( ) Other (specify) _____

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the requirements of the Federal privacy protection regulation and will be responsible for any charges incurred for this service.

I certify that I have received a copy of the authorization.

_____ _____
Signature **Date**

_____
Print Name

_____ _____
Name of Personal Representative **Relationship to Patient**