MAUI OPTOMETRY

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
MEDICAL RECORD RELEASE

PATIENT NAME: ___________________________ **DATE OF BIRTH:**___________________.

AT MY REQUEST, I AUTHORIZE:

NAME:_______________________________________.
ADDRESS:____________________________________.
PHONE:____________________ FAX:______________.

TO DISCLOSE THE FOLLOWING INFORMATION

☒ Any and all of the medical records pertaining to the treatment of the individual

☐ Other (please specify)____

TO MAKE THE DISCLOSURE TO:

NAME: Maui Optometry
ADDRESS: 32 Pa`a Street, Kahului, HI 96732
PHONE: 808-877-7828 FAX: 808-442-9764

PURPOSE OF DISCLOSURE ☐ the request of the individual / legal guardian:____________________

I understand than any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules.

I understand that I have the right to revoke this Authorization at any time, except to the extent action has been taken in response to this authorization, by giving written notice of revocation to the practice at the address noted above. I also understand that the revocation will not apply to my insurance company when the law provides and insurer with the right to contest a claim under my policy. (The written revocation must be legible and include the name and date of birth of the individual, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person / entity no longer authorized to receive the information, the signature of the person with legal authority for authorization / revocation, and their phone number)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility of benefits.
Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date or on the following date, event or condition:

I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

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Signature of patient / legal guardian *Relationship to patient / legal authority* *Date*