RETINA CONSULTANTS OF HAWAII

GREGG T. KOKAME, MD ~ JAMES C. LAI, MD
SARAH READ, MD PHD ~ ELYSSE S. TOM, MD ~ RAYMOND WEE, MD
Excellence through Compassionate Clinical Care and State of the Art Research

AUTHORIZATION TO RELEASE INFORMATION

I, _____ (Date of Birth: __/___/____), hereby authorize and request the release of medical information from:

_____

concerning the treatment rendered to me, and to disclose the following protected health information regarding my care. This information is to be released to:

Retina Consultants of Hawaii, Inc.
Name
98-1079 Moanalua Road, Suite 470
Address
Aiea, Hawaii 96701
City, State, Zip Code

(808) 487-8928 **Phone** **(808) 487-3699** **Fax**

Reports to be furnished:
- ☐ All Medical Records
- ☐ Ocular Records Only
- ☐ Fluorescein Angiography
- ☐ Fundus Photos
- ☐ Scans
- ☐ Other: _____

Information to be used for following purpose:
- ☐ For treatment at this facility
- ☐ For processing of insurance claim
- ☐ Other: _____

Unless otherwise indicated, the undersigned authorizes disclosure of the above-designated records generated at ANY TIME.

IF YOU DO NOT WISH THE TIME SPAN OF THIS AUTHORIZATION TO INCLUDE ALL RECORDS generated at any time, please indicate the TIME SPAN (and/or dates of treatment) FOR WHICH DISCLOSURE IS AUTHORIZED.

Time Span:

From:___/___/___ To:___/___/___

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (i.e. a letter) addressed to KELLI LUM. I am aware that my revocation is not effective to the extent that the persons I have 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 have no affect on my ability to obtain treatment from GREGG T. KOKAME, MD/JAMES C. LAI, MD/SARAH READ, MD, PHD/ELYSSE S. TOM, MD/RAYMOND WEE, MD/RETINA CONSULTANTS OF HAWAII, nor will it affect my eligibility for benefits.

It is the understanding of Gregg T. Kokame, MD/James C. Lai, MD/Sarah P. Read, MD, PhD/Elysse S. Tom, MD/Raymond Wee, MD and the staff that the information being released is privileged and confidential and will not be used for anything other than the intent of this request.

_____ _____ ___/___/_____
Name of Patient **Signature** **Date**

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