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:
_____*RETINA CONSULTANTS OF HAWAII, INC.*_____
concerning the treatment rendered to me, and to disclose the following protected health information regarding my care. This information is to be released to:

_____
Name

_____
Address

_____
City, State, Zip Code

_____ _____
Phone **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 <u>ALL RECORDS</u> generated at any time, please indicate the TIME SPAN (and/or dates of treatment) FOR WHICH DISCLOSURE IS AUTHORIZED.

<u>Time Span:</u>

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**