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Authorization for Release of Protected Health Information (PHI)

_____, hereby authorizes EyeSight Hawaii and its affiliated healthcare providers to release copies of Protected Health Information (PHI) described on the lines below to the following recipient:

Myself

Please release my records via:

- Pick-up at office
- Fax: _____
- Mail: _____

Other Recipient _____

Relationship _____

- Pick-up at office
- Fax: _____
- Mail: _____

My Doctor _____

- Phone: _____
- Fax: _____
- Mail: _____

The Patient understands and agrees that the PHI to be used or released includes any and all facts, records and opinions related to following treatment, condition, or research related to the Patient that took place with EyeSight Hawaii and its affiliated healthcare providers.

All notes / Procedure notes / Most recent exam notes / Other: _____

The purpose, reason, or necessity of the use or disclosure above-described PHI is as follows (“Purpose”):

I, the undersigned Patient or Representative, certify that I have read or otherwise understand this Authorization and that I am legally competent to sign this Authorization on behalf of myself.

(Authorized Signature)

_____/_____/_____
(Today’s Date)

(Printed Name of Patient or Representative)

_____/_____/_____
Patient’s Birthdate (mm/dd/yyyy)

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