JOHN OLKOWSKI, M.D.
Corneal, Cataract & Refractive Surgeon

KRISTIN HIRABAYASHI, M.D.
Corneal, Cataract & Refractive Surgeon

MICHAEL DASH, M.D.
Corneal, Cataract & Refractive Surgeon

Authorization for Release of Protected Health Information:

I,_____, hereby authorizes Dr._____/ Facility_____to release copies of my Protected Health Information (PHI) described on the lines below to the following recipient:

☐ **EyeSight Hawaii**
650 Iwilei Road, Suite 210
Honolulu, HI 96817
Telephone: 808-735-1935
Fax: 808-735-6875

☐ **EyeSight Hawaii - Maui**
33 Lono Avenue, Suite 260
Kahului, HI 96732
Telephone: 808-871-1411
Fax: 808-871-1441

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 Dr._____/ Facility_____.

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

TOPOGRAPHY, PACHYMETRY, MANIFEST REFRACTION, ALL NOTES

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

EyeSight Hawaii and its affiliated healthcare providers need to review and compare previous eye exam results.

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)