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Glaucoma & Cataract Refractive Surgeon

**MICHAEL DASH, O.D.**  
Doctor of Optometry

**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:** \_\_\_\_\_

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)