HIPAA Authorization For Release Of Information

Use This Form To Allow the Release of Your Personal Health Information

Please keep a copy for your records

1. **Name** _____ **Phone** _____

   Address _____ **Date of Birth** _____

2. **List the personal health information you want to give out**

   - For example: "The claims information related to my eye exam in January 2019," or "All my health information," or "All the records related to my eye problems"
   - You may also exclude some health information
     - For example: "all my health information except my financial payments" or "all my medical records except the field tests "

   _____

   _____

   ☐ Please check here if you authorize to give out information related to any of the following, should it be contained within your medical record:

   —HIV, AIDS, or AIDS-related complex diagnosis or treatment
   —alcohol or drug use, diagnosis, or treatment
   —mental health counseling, diagnosis, or treatment

3. **Name and address of the persons or organizations to give your personal health information**

   - For example: "My wife, Jane Doe" or "My grandson, John Doe"

   Name: _____ Address: _____

   _____

4. **Right to take back ("revoke")**

   - I may revoke this authorization at any time by giving written notice. I understand my revocation will NOT affect any disclosures that occurred before my written revocation and there may be other legal restrictions on my ability to revoke this authorization. For example, I understand that the revocation will not apply if this authorization was a condition for obtaining insurance coverage, when the law provides my insurer with the right to contest my policy or a claim under my policy.
   - If I do not revoke it, this authorization will expire on the following date or event: _____
     For example: "12/31/2022"
     - If a date or event is not specified, this authorization will expire **one year** from the date of signature below
   - To revoke this authorization, I will write a letter including the following:
     - My name, address, and member number
     - The names of the persons or organizations I no longer wish to receive my personal health information
     - My signature
   - I will mail or fax the letter to: Nora M.Y. Chan O.D., Inc.
     377 Keahole Street A14
     Honolulu, HI 96825
     Fax: 808-395-2448

6. **I authorize to give out the protected health information** described above to the persons or organizations I named on this form. This authorization is voluntary. I understand that the releasee will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed by law. I understand my protected health information may be re-disclosed by the recipient(s) without my permission and may no longer be protected by law.

Signature _____ Date _____