



JENKINS EYE CARE

615 Piikoi Street, Suite 205 Honolulu, Hawaii 96814

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize _____ to release/obtain information or records of
(Provider/Healthcare Facility)

Patient Name: _____	Date of Birth: _____
Address: _____	
Phone: _____	

TO: _____ (Name or Institution)
Address: _____

RECORDS AUTHORIZED TO BE RELEASED: DATE(S) OF SERVICE:

<input type="checkbox"/> Office exam notes	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> X-ray/MRI reports	<input type="checkbox"/> VF, photos	<input type="checkbox"/> Other (specify): _____	

THIS INFORMATION WILL BE USED FOR THE PURPOSE OF:

<input type="checkbox"/> Physician follow-up	<input type="checkbox"/> Insurance purposes	<input type="checkbox"/> Legal purposes
<input type="checkbox"/> At the request of the individual	<input type="checkbox"/> Other _____	

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider. But that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- Federal privacy regulations will no longer apply to the information disclosed, and that may re-disclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Signature Patient or Representative

Name of Representative (Print)

Witness Signature

Date