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AUTHORIZATION FOR USE OF DISCLOSURE OF MEDICAL INFORMATION

I authorize _____ to release the medical information of:

PATIENT NAME:_____ Date of Birth:_____

Patient Phone #: _____ Phone:_____

Facility Address: _____ Fax #:_____

TO: BLANE K. CHONG, M.D. 3221 WAIALAE AVE. STE 390, HONOLULU, HI 96816

Information to be disclosed:	*Purpose of Use and/or Disclosure:*
Date(s) of Service: ❑ History & Physical ❑ Consultations ❑ Laboratory Results ❑ X-ray/Imaging Reports ❑ Entire Record ❑ Other Please Specify_____	❑ At the request of the patient ❑ Legal Purposes ❑ Insurance ❑ Physician Follow-Up Other:_____

_____ (Initial) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, behavior or mental health services. (if I do not specifically agree, this information will not be disclosed.)

*Unless otherwise revoked, this authorization will expire on the following date or event _____. If a date or event is not specified, this authorization will expire one year from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and Blane K. Chong, M.D. will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for (i) research-related treatment; or (ii) health care provided solely for disclosure to a third party; or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

I understand that I may revoke this authorization at any time by notifying the office of Blane K. Chong, M.D, in writing of my revocation. This is described in the Notice of Privacy Practices. I understand that the revocation will not apply to any information that already was released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I hereby release Blane K. Chong, M.D. from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Blane K. Chong, M.D.

Requestor: _____ _____
Signature Print Name

Relationship: _____ _____
Relationship to Patient -Complete only if requestor is not patient Date