AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure. ☐
   This information may be disclosed to and used by the following individual organization. ☐

David S. Crow, M.D., Ph.D., LLC
Andrew Don, M.D., FACS
Stephen Sussman, M.D.
71 Kanoa St., Suite 101
Wailuku, HI 96793
Ph 808-244-5999 Fax 808-244-1295

_____

_____

_____

_____

Phone: _____

Fax: _____

For the purpose of: _____

3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

_____ Complete Health Records _____ Radiology Reports

_____ Physical Exam _____ Consultation Reports

_____ Audiometric Records _____ Lab Results

_____ Other (please specify): _____

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

6. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

7. ***There will be a charge of $0.25 per page that is copied.***

Signature of patient or legal representative: _____ Date: _____

Signature of witness: _____ Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243) and federal law 42 CFR, part II.