

Advanced Reproductive Center of Hawaii

1319 Punahou Street, Suite 520, Honolulu, Hawaii 96826
Phone: (808) 949-6611 Fax: (808) 949-6610

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name

Date of Birth

SS#

Phone Number

I authorize:

to release medical information to:

Dr. Christopher Huang
1319 Punahou Street, #520
Honolulu, HI 96826
FAX: 949-6610

PURPOSE OF THIS DISCLOSURE:

- Transferring to New Physician/Continued Medical Care Insurance Application
 Disability Determination Legal Investigation Personal Use
 Other, please specify _____

INFORMATION TO BE DISCLOSED: (Note: Please see Disclosures Requiring Special Consent)

Date Range: _____ to _____

- Office Visit Notes Ultrasounds/Imaging Reports Operative Reports
 IVF Cycle Report(s) Ovulation Induction/IUI Notes Laboratory Reports
 Other: _____

YOUR RIGHTS REGARDING THIS AUTHORIZATION

Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Advanced Reproductive Center of Hawaii. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. Advanced Reproductive Center of Hawaii will not condition treatment on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

Further Disclosure: I understand that federal privacy regulations will no longer apply to the information disclosed

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed unless otherwise indicated.

_____ Date (Optional)

Patient or Legal Representative Signature/Relationship

Date of Signature

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of health information relating to testing, diagnosis and treatment for:

- AIDS/HIV Sexually Transmitted Diseases Alcohol/Drug Use Developmental Disabilities

Patient or Legal Representative Signature/Relationship

Date of Signature