

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM
AIEA PEDIATRICS, LLC.**

Patient's Name: _____ Date of Birth: _____

I hereby authorize Dr. Brent K. Tamamoto to Use or Disclose My Health Information to

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

You may use or disclose the following health care information (check all that apply):

- All my health information
- My health information relating to the following treatment or condition: _____
- My health information for the date(s): _____
- Other: _____

Reason(s) for this authorization (check all that apply):

- At my request
- Other (specify): _____

This authorization ends: Date: _____

If no end date is authorized, this form will end one year from date of signature.

My Rights

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:
 - To take part in a research study or
 - To receive health care when the purpose is to create health information for a third party.
- I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Dr. Brent Tamamoto based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
 - Fill out a revocation form. The form is available from the office or
 - Write a letter to the office.
- Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Signature of Patient's Personal Representative

Date

Printed Name of Personal Representative

Relationship to Patient