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

Patient's Name:_____ Date of Birth:_____

I hereby authorize _____ to Use or Disclose My Health Information to: (**PREVIOUS** Doctor's Full Name)

Dr. Brent Tamamoto
Aiea Pediatrics, LLC
99-080 Kauhale Street, C-22
Aiea, Hawaii 96701
(808) 487-1600 office; (808) 487-1601 fax
Email (Not secure. Please password protect all information): frontdesk@aieapediatrics.com

PREVIOUS Doctor's Contact Information:

Phone number: _____

Fax number: _____

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

___ All my health information
___ All my immunization records
___ 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