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AUTHORIZATION FOR USE OF DISCLOSURE OF MEDICAL INFORMATION

I authorize _____ to release the 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

<p><i>Information to be disclosed:</i> Date(s) of Service: _____ <input type="checkbox"/> History & Physical <input type="checkbox"/> Consultations <input type="checkbox"/> Laboratory Results <input type="checkbox"/> X-ray/Imaging Reports <input type="checkbox"/> Entire Record <input type="checkbox"/> Other Please Specify _____</p>	<p><i>Purpose of Use and/or Disclosure:</i> <input type="checkbox"/> At the request of the patient <input type="checkbox"/> Legal Purposes <input type="checkbox"/> Insurance <input type="checkbox"/> Physician Follow-Up Other: _____</p>
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_____ (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