NATHAN FUJITA MD. | OBSTETRICS & GYNECOLOGY
Queen's Physicians' Office Building II | 1329 Lusitana Street, Suite 402 Honolulu, Hawaii 96813
Telephone (808) 538-3787 | Fax (808) 538-7873

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize* **to disclose health information for:**

Dr. ______________________________
Doctor Name (please print clearly)

____
Address

____

____
Phone Number

____
Patient Name (please print clearly)

____
Address

____

____
Phone Number

as follows: Copies of *

☐ Medical records ☐ Laboratory reports ☐ X-ray / imaging reports ☐ Other ______________________________
(please specify)

To: Nathan Fujita, M.D. for the purpose(s) of ☐ Insurance ☐ Legal purposes ☐ At the request of the patient
1329 Lusitana Street, Suite 402
Honolulu, Hawaii 96813
☐ Other ______________________________
(please specify)

This authorization covers health information for the period of time from* ☐ the first visit to the last visit *or*

☐ _____ /_____ /_____ - _____ /_____ /_____
Month Day Year Month Day Year

(Initials)

_______ 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, or behavioral or mental health services. If I do not specifically agree, this information will not be disclosed.

_______ This authorization shall remain in effect for one (1) year from the date of signature below, unless prior written notice of revocation is received and approved by this office earlier.

_______ I understand that I can revoke this authorization at any time by notifying the privacy officer and/or officemanager in writing. I understand that the revocation will not apply to any action that already was taken in reliance on this authorization. Revocations are not effective until received and verified by the Privacy Officer and/or Office Manager.

_______ I understand that this authorization is voluntary and that I can refuse to sign. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on the signing of this authorization except as allowed under federal privacy laws for (a) research-related treatment, (b) health care provided solely for disclosure to a third party or (c) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

_______ A reasonable fee may be charged for duplication of records. An estimate of those charges may be provided upon request prior to duplication. 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 and/or State privacy regulations.

_______ This form and the terms listed are subject to change without prior notice.

_______ I hereby release Dr. ____________________________and staff from any and all liability and claims of any nature whatsoever pertaining to the disclosure of information or of any professional opinions, findings or recommendations as contained in the medical records released to or by the above mentioned doctor.

Signed* ______________________________
(Patient's / Legal Guardian's Authorized Agent's Signature)

Date* ______ /______ /_______
Month Day Year

____
(Print Name if not Patient's signature)

____
(Relationship to Patient)

* Items that MUST be completed for authorization to be valid.

Please return a copy of this authorization with your report(s). Thank you for your kind cooperation.