

Authorization To Release Medical Information

Welcome to Advanced Reproductive Center of Hawai'i. Please take a moment to provide the information requested below so our team can better serve you.



Advanced Reproductive
Center of Hawai'i

PATIENT NAME _____ DATE OF BIRTH _____

SS# _____ PHONE NUMBER _____

I authorize: _____ To release medical information to:

_____ **Dr. Christopher Huang / Dr. Christina Arnett**

_____ **1319 Punahou Street, #510**

_____ **Honolulu, HI 96826**

FAX: 949-6610

Purpose of this Disclosure

Transferring to New Physician/Continued Medical Care	Insurance Application
Disability Determination	Legal Investigation
Other (Please specify) _____	Personal Use

Information to be disclosed (Note: Please see Disclosures requiring special consent below)

Date Range _____ to _____

Ultrasounds/Imaging Reports	Operative Reports	Ovulation Induction/IUI Notes
Laboratory Reports	IVF Cycle Report(s)	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 Hawai'i. 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 Hawai'i 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
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PATIENT OR LEGAL REPRESENTATIVE SIGNATURE/RELATIONSHIP

DATE OF SIGNATURE