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, #1180
Honolulu, HI 96826

FAX: 949-6610

Purpose of this Disclosure

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

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

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE/RELATIONSHIP _____ DATE OF SIGNATURE _____