JOHN OLKOWSKI, M.D.
Corneal, Cataract & Refractive Surgeon

KRISTIN HIRABAYASHI, M.D.
Corneal, Cataract & Refractive Surgeon

MICHAEL DASH, O.D.
Doctor of Optometry

Authorization for Release of Protected Health Information (PHI)

_____, hereby authorizes EyeSight Hawaii and its affiliated healthcare providers to release copies of Protected Health Information (PHI) described on the lines below to the following recipient:

☐ Myself
Please release my records via:
□ Pick-up at office
□ Fax:_____
□ Mail:_____
_____

☐ Other Recipient_____
Relationship_____
□ Pick-up at office
□ Fax:_____
□ Mail:_____
_____

☐ My Doctor_____
□ Phone:_____
□ Fax:_____
□ Mail:_____
_____

The Patient understands and agrees that the PHI to be used or released includes any and all facts, records and opinions related to following treatment, condition, or research related to the Patient that took place with EyeSight Hawaii and its affiliated healthcare providers.

All notes / Procedure notes / Most recent exam notes / Other:_____

The purpose, reason, or necessity of the use or disclosure above-described PHI is as follows ("Purpose"):
_____

I, the undersigned Patient or Representative, certify that I have read or otherwise understand this Authorization and that I am legally competent to sign this Authorization on behalf of myself.

_____ _____/_____/_____
(Authorized Signature) (Today's Date)

_____ _____/_____/_____
(Printed Name of Patient or Representative) Patient's Birthdate (mm/dd/yyyy)

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