WAYNE B.L. CHUN M.D., LLC
INTERNAL MEDICINE   BOARD CERTIFIED

1351 South Beretania Street, Suite J
Honolulu, Hawaii 96814
Ph: (808) 744-2486   Fx: (808) 744-2489

**CONSENT TO RELEASE**
**PROTECTED HEALTH INFORMATION PURSUANT TO H.R.S. 323C**

Authorization is hereby given to Wayne Chun, M.D. to disclose and be furnished any and all health care information including medical records, reports, x-rays, diagnostic test results, bills, and payment records with respect to medical treatment or qualified healthcare operations provided to:

a) any health insurance plan or company that provides insurance coverage for me for the purpose of payment of charges;
b) any insuance company that provides liability insurance coverage for Dr. Wayne chun for the purpose of evaluating the treatment rendered to me.
c) mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results. If this medical record contains infromation about HIV testing and/or AIDS diagnosis or treatment, separate consent must be given to have this information released.

☐ I consent to have my HIV testing, AIDS diagnosis, drug and/or alcohol abuse and/or mental health records released.

☐ I do not consent to have my HIV testing, AIDS diagnosis, drug and/or alcohol abuse and/or mental health records released.

Or

d) to (specifiy individual/group/organization) ______________________________ for the purpose of ______________________________

This authorization also gives Wayne Chun M.D. permission to speak to the following spouse, family member, relative or friend regarding my medical information and treatment:

| Name | Relationship | Name | Relationship |
|---|---|---|---|
| | | | |
| | | | |

This authorization shall cover the perid of time from my fitrst visit to my last visit.
I understand that I can revoke this authorization at any time.
This authorization shall end two years after the date of my last visit.
I release Wayne Chun M.D. from all legal responsibility that may arise from this authorization.

______________________ Patient Signature

______________________ Date

______________________ Print Patient Name

______________________ Date of Birth

______________________ Signature of Parent or Leagal Guardian if Minor