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

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

______________________	______________________	______________________
Name-Print	Birthdate	Social Security Number

AUTHORIZE

______________________	______________________	______________________
Name-Print	Address	City State Zipcode

My authorization applies to the disclosure of the information below. Only this information may be used/or disclosed pursuant to this authorization. (Check all that apply.)

☐ Medical Records ☐ Clinical Notes Lab Results ☐ X-Ray results ☐ HIV test results
☐ Other ____

I authorize:

☐ Wayne Chun M.D., LLC, 1351 South Beretania Street, Suite J, Honolulu, Hawaii 96814 to make authorized use of my protected health information.

☐ The following persons to receive my protected health information:

Name	Relationship	Name	Relationship
______________	______________	______________	______________

I understand that, if my protected health information is disclosed to someone who is not required to comply with the Federal privacy protection regulations, then the information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this authorization at any time. My revocation MUST be in WRITING (e.g. letter). I am aware that my revocation is not effective to the extent that the persons I authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Wayne B.L. Chun M.D., nor will it affect my eligibility for benefits.

My protected health information will be used or disclosed upon request for the following purposes:
☐ Personal Records ☐ Continued Medical Care ☐ Legal Action ☐ Insurance Claim
☐ Other ____

I UNDERSTAND THAT I HAVE A RIGHT TO INSPECT AND COPY MY OWN PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED IN ACCORDANCE WITH THE REQUIREMENT OF THE FEDERAL PRIVACY PROTECTION REGULATION AND **WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED FOR THIS SERVICE.**

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION.

______________________	______________________
Patient Signature	Date
______________________	______________________
Print Patient Name	Date of Birth
______________________	______________________
Name of Personal Representative	Relationship to Patient