AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM AIEA PEDIATRICS, LLC.

Patient's Name:_____ Date of Birth:_____

I hereby authorize Dr. Brent K. Tamamoto to Use or Disclose My Health Information to

Name (or title) and organization:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone number: _____ Fax number: _____

Email address: _____

You may use or disclose the following health care information (check all that apply):

___ All my health information
___ All my immunization records
___ My health information relating to the following treatment or condition:_____
___ My health information for the date(s):_____
___ Other:_____

Reason(s) for this authorization (check all that apply):

___ At my request
___ Other (specify):_____

This authorization ends: Date:_____
If no end date is authorized, this form will end one year from date of signature.

My Rights

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:
    - To take part in a research study or
    - To receive health care when the purpose is to create health information for a third party.
- I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Dr. Brent Tamamoto based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
    - Fill out a revocation form. The form is available from the office or
    - Write a letter to the office.
- Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Personal Representative's Email Address: _____
Please provide an email address if you would like a copy of the medical records

_____ _____
Signature of Patient's Personal Representative Date

_____ _____
Printed Name of Personal Representative Relationship to Patient