SCOTT T. KAWAMOTO, M.D., LLC ▪ RHEUMATOLOGY

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

1. **I AUTHORIZE:**

_____
Name of sending person/organization

_____
Street Address

_____
City State Zip Code

2. **TO RELEASE TO:**

_____
Name of receiving person/organization

_____
Street Address

_____
City State Zip Code

***PATIENT NAME:** _____

Birth Date: _____ Phone #: _____

***Information to be disclosed:**	***Purposes for Use and/or Disclosure:**
Date(s) of Service: _____ through _____ ☐ History & Physical ☐ X-Ray/Imaging Reports ☐ Consults ☐ Entire Record ☐ Laboratory Results ☐ Other: _____ Please specify: _____	☐ Physician follow-up ☐ At the request of the individual ☐ Legal Purposes ☐ Insurance ☐ Worker's Compensation Other: _____

_____ **(Initial) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services. (If I do not specifically agree, this information will not be disclosed):**

***Unless otherwise revoked, this authorization will expire on the following date or event:** _____
If a date or event is not specified, this authorization will expire one year from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and SCOTT T. KAWAMOTO, MD will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: (i) research-related treatment; or (ii) health care provided solely for disclosure to a third party or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

I understand that I may revoke this authorization at any time by notifying SCOTT T. KAWAMOTO, MD, in writing, of my revocation. This is described in the Notice of Privacy Practices of SCOTT T. KAWAMOTO, MD. I understand that the revocation will not apply to any information that already was released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I hereby release SCOTT T. KAWAMOTO, MD from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by SCOTT T. KAWAMOTO, MD.

I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

***Requestor**: _____ _____
SIGNATURE PRINT NAME

***Relationship**: _____ _____
RELATIONSHIP TO PATIENT DATE
(Complete only if requestor is not patient)

***Items that MUST be completed for authorization to be valid (in bold).**