



**Authorization for Release of Protected Health Information:**

\_\_\_\_\_ hereby authorizes Dr. \_\_\_\_\_ to release copies of Protected Health Information (PHI) described on the lines below to the following recipient:

**EyeSight Hawaii**  
**3660 Waialae Avenue Ste 304**  
**Honolulu, HI 96816**  
**Telephone: 808-735-1935**  
**Toll Free: 877-735-1935**  
**Fax: 808-735-6875**

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 Dr. \_\_\_\_\_.

**All refraction notes**

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

**Dr. Olkowski and Dr. Louie need to review and compare previous eye exam results.**

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)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name of Patient)

\_\_\_\_\_  
Patient’s Birthdate