Thomas S. Kosasa, M.D.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Pursuant to federal laws governing HIPAA and Chapter 323-C of the Hawaii Revised Statues, I hereby authorize Dr. Thomas Kosasa to disclose my medical records to" (a) any health insurance plan or company that provides insurance coverage for me or the named patient, for the purpose of payment of charges; (b) any insurance company that provides liability insurance to Dr. Thomas Kosasa, to evaluate clinical performance; (c) to any medical doctors, workers' compensation, no-fault, temporary disability insurance or administrative proceeding for the purpose of evaluating my medical condition.

I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

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I authorize the following persons (or class of persons) to receive my protected health information:

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

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may revoke this authorization in writing at any time. My revocation must be in writing (e.g.) addressed to Susan Kosasa, Privacy Officer. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance on this authorization.

This authorization expires on ______________________________________.

I certify that I have received a copy of the authorization.

____________________________________ ______________________________
Signature of Patient Date

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Patient Name (Print)