# AUTHORIZATION TO RELEASE HEALTH INFORMATION

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**Patient Name:**_____ **DOB:**_____

**I hereby authorize Dr. Hidenao Kimura to release my private health information to the following person(s):**

| NAME | RELATIONSHIP | PHONE |
|---|---|---|

**1)**_____

**2)**_____

**3)**_____

**Please Initial the Information to be released:**

_____ **Appointment Scheduling**

_____ **Office Visit Details (Except: Mental and Sexual Health)**

_____ **Lab Results (Except: HIV, AIDS, STD, and Pregnancy Results)**

_____ **Imaging Results**

_____ **Medications (Refills, Directions, and Treatment For)**

_____ **Billing and Insurance (Including: what was billed, past due, and collections)**

_____ **Ok to Leave Detailed Messages on My Cell/Home Voicemails.**

**I am authorizing the above release on my own free will and I am aware that I can terminate this consent at any time. This Consent will expire 1 year from the date of signature. Dr. Kimura and his Staff will not honor this consent after the date below. Therfere, a new consent Must be Signed and Renewed Annually.**

**Patient Signature:** _____ **Date:** _____

**Staff Signature:** _____ **Date:** _____