Aloha Stadium Dental Associates
Taking care of your smile

4510 Salt Lake Blvd #B3 Honolulu, HI 96818

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Know Your Rights

Your decision to sign this Authorization is voluntary. Aloha Stadium Dental Associates will not refuse treatment to you if you refuse to sign this Authorization.

When your protected health information is released as provided by this Authorization, please be aware that the named recipient (above) may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

Patient Signature

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting Aloha Stadium Dental Associates to release, use or disclose my protected health information only with other health care providers and or insurance companies working in partnership with your care.

Signature	Date
Print Name	Witness (Optional)

Representative Signature

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use or disclosure the patient's protected health information only with other health care providers and or insurance companies working in partnership with your care.

Signature	Date
Print Name	Relationship to Patient

☐ Parent ☐ Guardian ☐ Power of Attorney