WINDWARD ORTHOPAEDIC GROUP, INC.

As provided under Title 19, Chapter 323C of the Hawaii Revised Statues as it pertains to Protected Health Information,

I,_____, hereby authorize Windward Orthopaedic Group, Inc, and /or its agents to disclose my protected health information, the protected health information of my dependent children as well as any individual for which I have legal guardianship. The health information includes copies of my medical and/or financial records as well as copies of medical and/or financial records pertaining to my dependent children and any individual for which I have legal guardianship to:

a. **any health insurance plan or company that provides insurance coverage to me, my family and/or individuals from whom I have legal guardianship for the purpose of payments of charges;**
b. **any insurance company that provides liability insurance coverage for Windward Orthopaedic Group, Inc. and/or its agents, for the purpose of evaluating the treatment rendered to me;**
c. **any insurance company that provides Worker's Compensation insurance coverage to my employer under which coverage I have entered a claim;**
d. **any insurance company that provides No-Fault automobile insurance coverage to me and/or my family;**
e. **any allied health organization or professional involved with my treatment, the treatment of my family and/or individual for whom I have legal guardianship. The allied health organizations or professionals include but are not limited to referring physicians, physical therapists, medical consultants, x-ray and laboratory services, hospitals and surgical centers, etc., and/or**
f. **to_____**

_____for the

purpose of _____.

This authorization shall remain in effect for the period of time as provided for by law. I understand I can revoke this authorization at any time and that the revocation must be in writing.

I do hereby acknowledge and understand that without authorization, medical records and other information will not be released to any organization or individual and that I will be responsible for any and all charges for services incurred on my behalf or on behalf of my dependent children and/or any individual for which I am the legal guardian.

Check One: _____ I do authorize the release of protected health information.

_____ I <u>do not</u> authorize the release of protected health information.

Signed _____ Date: _____

Print Name _____Relationship: _____
(For minor or legal guardian)

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