Member
American Optometric Association

CLAYTON Y. GUSHIKEN, O.D., F.C.O.V.D
DOCTOR OF OPTOMETRY
FELLOW, COLLEGE OF OPTOMETRISTS IN VISION DEVELOPMENT

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Clayton Y. Gushiken, O.D., FCOVD, to obtain information or records of:

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

TO: _____
(Name or Institution)

Address: _____

_____

RECORDS AUTHORIZED TO BE RELEASED:

DATE(S) OF SERVICE: _____

- ____ Office Exam Notes
- ____ Progress Reports
- ____ History & Physical
- ____ OT/PT Reports/Notes
- ____ Other (specify): _____

THIS INFORMATION WILL BE USED FOR THE PURPOSE OF:

- ____ Doctor Follow-up
- ____ Insurance Purposes
- ____ Legal Purposes
- ____ At the request of the individual
- ____ Other (specify): _____

2353 SOUTH BERETANIA STREET, SUITE 101 HONOLULU, HAWAII 96826 TELEPHONE: 808-941-3811

This authorization will expire one year from the date of signature below.
I understand that I can revoke this authorization at any time by writing to the health care provider; however, revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____

Signature of Patient or Representative

_____

Name of Representative (Print)

_____

Date