Maui Medical Group

# Authorization for Release of Protected Health Information

***Wailuku*Kahului*Pukalani*Kihei*Lahaina*Clinics***

**Patient Name:** _____ **Aka:** _____
**DOB:** _____ **MRN:** _____
**SSN (last 4 digits only):** _____

**YOU MAY DISCLOSE THE FOLLOWING HEALTHCARE INFORMATION (CHECK ALL THAT APPLY)**

- **All of health information maintained by Maui Medical Group. I understand that the records may be voluminous in its entirety and I agree to pay reasonable charges with Maui Medical Group providing copies of medical records.**
- **My health information relating to the following treatment or condition(s):** _____
- **My health information for the dates of service(s):** _____
- **Other:** _____
- ***FEES FOR COPIES OF MEDICAL RECORDS MAY APPLY TO CERTAIN REQUESTS***

**Disclose the following information:**

☐ **Clinic Records** ☐ **X-ray films** ☐ **X-ray reports** ☐ **Lab Results** ☐ **Immunizations**
☐ **Records of provider(s):** _____

**Types of record format:**

☐ **Paper** ☐ **CD** ☐ **Flash Drive** ☐ **Email Address:** _____

**Purpose of release:**

☐ **Continued Health Care** ☐ **Legal Purposes** ☐ **Insurance** ☐ **School** ☐ **Personal**
☐ **Workers Compensation** ☐ **Other (specify):** _____

**Information Release to:**
**Name of Person/Institution/Physician:** _____
**Address:** _____
**Phone:** _____ **Fax:** _____
**Email:** _____

**I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollments). However, I do have to sign an authorization form: To take part in a research study or to receive health care when the purpose is to create health information for a third party.**
**I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Maui Medical Group based upon this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance. For questions on how to revoke this form please contact our Medical Records Department in writing or by phone.**
**Medical Records phone: 808-242-4203 fax: 808-243-2341**
**Once the Medical Records Department discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. This authorization will expire in 90 days from date of signature. A fax or copy of this authorization may be used as an original.**

_____ _____
**Patient or Legal Authorized Signature** **Date**

_____ _____
**Printed Name if signed on the behalf of the patient** **Relationship (parent, legal guardian, personal representative, etc.)**

***FEES FOR COPIES OF MEDICAL RECORDS MAY APPLY***