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 receive 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: 808-242-6464 FAX: 808-243-2341 EMAIL: medicalrecords@mauimedical.com
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.)

PRE-PAYMENT CHARGES FOR PATIENT MEDICAL RECORDS COPIES
$6.25 FLAT FEE FOR PERSONAL/IMAGING $15.00 FOR 2nd COPY/BILLING RECORDS $10.00