Maui Medical Group

Authorization for Release of Protected Health Information

Wailuku*Kahului*Pukalani*Kihei*Napili*Clinics

Patient Name: _____ Aka: _____

DOB: _____ MRN: _____

YOU MAY DISCLOSE THE FOLLOWING HEALTHCARE INFORMATION (CHECK ONLY ONE OPTION)

☐ Form Completion (a substitute form or relevant medical records may be released)

☐ Last 2 years of **MAUI MEDICAL GROUP** records

☐ Records as specified. You must complete Step 1 and Step 2 below.

Step 1: Enter date range or date(s) of the records to be released: _____

Step 2: Select types of records to be released:

☐ Clinic Records ☐ X-ray films ☐ X-ray reports ☐ Lab Results ☐ Immunizations

☐ Copays & Deductibles ☐ Itemized Billing

☐ Other (provider, department, specialty): _____

Types of record format: (CHECK ONE)

☐ Paper ☐ CD ☐ Flash Drive ☐ Email ☐ Fax

Purpose of release:

☐ Continued Health Care ☐ Legal Purposes ☐ Insurance ☐ School ☐ Personal*

☐ Workers Compensation ☐ Other (specify): _____

FEES FOR COPIES OF MEDICAL RECORDS MAY APPLY

Information Release to: (**please complete all necessary fields)**

Name of Person/Institution/Physician: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

I understand I do not have to sign this authorization form 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.

Once the Medical Records Department discloses health information, privacy laws may no longer protect it, and the person or organization that receives it may re-disclose it. This authorization will expire in 90 days from the date of signature. A fax or copy of this authorization may be used as the original.

I may revoke this authorization in writing and understand that doing so will 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

_____ _____

Patient or Legal Authorized Signature Date

_____ _____

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