AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO PEARL CITY MEDICAL ASSOCIATES, INC.

Patient's Name:_____ Date of Birth:_____

I hereby authorize _____ to furnish the information indicated below to:

_____, MD
PEARL CITY MEDICAL ASSOCIATES, INC.
98-1079 Moanalua Rd., Suite 500
Aiea, HI 96701

Information to be released (check all that apply):

- ☐ Complete medical record
- ☐ Clinical notes (examination notes)
- ☐ Consultation report
- ☐ Other (describe):_____
- ☐ Operative report
- ☐ Laboratory report
- ☐ Radiology report

Dates of care: _____ to _____

The information authorized for release will be used for the following purpose:

_____

If records requested include information relating to treatment for HIV/Aids:
☐ I authorize release ☐ I do not authorize release of that portion of my medical record.

If records requested include information relating to treatment at a facility for substance or alcohol abuse:
☐ I authorize release ☐ I do not authorize release of that portion of my medical record.

If records requested include information relating to treatment at a mental health facility:
☐ I authorize release ☐ I do not authorize release of that portion of my medical record.

This authorization expires on: _____(date); or
☐ upon release of the requested information; or
☐ other (specify): _____

- I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying our office in writing. However, if I do so, I understand that my revocation will not affect any actions taken by my physician before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits (applicable only if this practice is seeking authorization for use or disclosure).

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Personal Representative* (if applicable) Relationship to Patient
*Attach documentation of authorization

FOR OFFICE USE:
Copy of authorization form given to patient (if required or requested):_____
Records released on: _____ Via: Mail ☐ Fax: ☐ Pickup: ☐
By: _____