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

I authorize _____ to release the protected health information of the patient named below:

∗Patient Name: _____ ∗Date of Birth: _____
Address: _____
Phone: _____

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

∗Information to be disclosed:
Date(s) of Service: _____
_____ Entire Medical Record
_____ Medical Bills
_____ Other: Please specify:
_____

∗Purposes of Use and /or Disclosure:
_____ Legal Purposes
_____ At request of patient
_____ Other:
_____

_____ **(Initial)** I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), or HIV, alcohol and/or drug abuse treatment, or behavioral or mental health services (unless I specifically agree, the information will not be disclosed).

Unless otherwise revoked, this authorization will expire on the following date or event: _____. If a date or event is not specified, this authorization will expire one year from the date of my signature below.

This authorization is voluntary. I understand that _____ will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed by law.

I understand that I may revoke this authorization at any time by notifying _____ in writing, of my revocation. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization and there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the right to contest a claim under my policy or my policy itself.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under the federal privacy regulations.

I release _____ from all liability and claims whatsoever pertaining to the disclosure of information as contained in the records released pursuant to this authorization.

_____ _____
∗Signature of Patient or Legally Authorized Representative+ ∗Date

_____ _____
∗Printed Name of Patient or Legally Authorized Representative+ ∗Relationship to Patient, if applicable

∗+Attach documentation/proof of legal authority

∗Items must be completed for authorization to be valid.

FOR OFFICE USE:
Copy given to patient/legal representative: _____