AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
To Worker's Compensation, Auto Accident, or Other Third Party Liability Carrier

☐ Worker's Compensation ☐ Auto Accident ☐ Other Third Party Liability

Patient's Name:_____ Date of Birth:_____

I hereby authorize PEARL CITY MEDICAL ASSOCIATES, INC. to furnish my health information to:

Name of insurance company: _____

Date of injury/illness: _____ Policy/Claim #:_____

The health information to be released includes copies of my medical record. Dates of care include the period of time from my first visit to my last visit for the injury/illness.

Pearl City Medical Associates, Inc. may provide information over the telephone if requested by the carrier.

The information will be used for the purpose of obtaining payment for the services provided by my physician(s) at Pearl City Medical Associates, Inc.

This authorization will expire when payment has been received for the last visit for the injury/illness.

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.

- 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 this office in writing. However, if I do so, I understand that my revocation will not affect any actions taken by Pearl City Medical Associates, Inc. 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

Copy of authorization form given to patient: _____