PANIOLO PEDIATRIC AND FAMILY MEDICINE INC.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

This form permits PANIOLO PEDIATRIC AND FAMILY MEDICINE INC. (Practice) at P.O. Box 6149 Kamuela, HI 96743 Phone: (808)887-6543 Fax#: (808)887-6294. WWW.Paniolo.Health to use and/or release the patient's health information for the purpose(s) described below.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ **Main Contact Number:** (___) _____
mm/dd/yyyy ☐ Home ☐ Cell ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

RECEIPIENT(S): This practice may use and/or release the information checked below to the following person or entity for the purpose(s) listed on this form.

Name: _____

Contact Person/Department: _____ Phone: (___) _____

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

CHECK THE TYPE(S) OF INFORMATION TO BE USED AND/OR RELEASED:

☐ Entire record ☐ Billing/insurance records ☐ Office visit notes ☐ Psychotherapy Notes*

*If this request is for psychotherapy notes, any other records must be requested on a separate form. (No other boxes should be checked)

☐ Lab/diagnostic results related to: _____ ☐ Records from: _____ to _____
type mm/dd/yyyy mm/dd/yyyy

☐ Records specific to a certain condition/treatment: _____

☐ Clinical images (e.g., X-ray)

☐ Other (describe): _____

Photos & Multimedia: ☐ Photo received from patient or personal representative

☐ Photo taken by staff (e.g., pre/post procedure) ☐ Other: _____

Post Photos/Images: ☐ In Office ☐ On website ☐ Other: _____

Do not include:

☐ Mental health records (Rx, diagnosis, etc.) ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

FORMAT/DELIVERY (if a release)

☐ Paper/mail ☐ Email: _____

☐ USB/CD-ROM ☐ Fax: (___) _____

☐ Secure Portal (name): _____ ☐ Other: _____

Requests for information to be released to third parties must be sent in a secure manner.

(Continued on back)

PURPOSE FOR THE USE OR RELEASE:

_____

_____

☐ This information will be used for marketing or fundraising activities. The practice/recipient will receive direct or indirect payment.

☐ This practice will receive direct or indirect payment that is more than the usual fee charged to prepare and release the information (e.g., a sale of PHI).

EXPIRATION DATE OR EVENT (not needed if this authorization was started by the patient)

☐ One-time use/release of information ☐ This information may be used/released until: _____
mm/dd/yyyy

☐ Release this information until the end of a treatment or other event (e.g., physical therapy): _____

_____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative.

_____ _____
Patient or Personal Representative Signature Date mm/dd/yyyy

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

_____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____
mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____
mm/dd/yyyy

Use/Release date(s): _____ ☐ Fee charged: _____
mm/dd/yyyy

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes: _____

_____