PANIOLO PEDIATRIC AND FAMILY MEDICINE INC.

Kamuela Office
64-1032 Mamalahoa Hwy., Suite 204
PO BOX 6149 Kamuela, HI 96743-6149
Ph: (808) 887-6543 Fax: (808) 887-6294

Kona Office
75-170 Hualalai Rd suite D214
Kailua Kona, Hi 96740
Ph: (808) 325-5805 Fax: (808) 657-4796

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ D.O.B: _____

I HEREBY AUTHORIZE **PANIOLO PEDIATRIC AND FAMILY MEDICINE, INC.** TO RELEASE MY CHILD'S MEDICAL RECORDS TO:

Name: _____
Phone: _____Fax: _____
Address: _____
_____

Description of information to be released:

Summary of care, Medication list, last 12 months of acute visits, the last physical, Immunization record.

Other_____

I specifically authorize the release of information relating to:

- o Substance abuse (including alcohol/drug abuse)
- o Mental Health (including psychotherapy notes)
- o HIV related information (AIDS related testing)

Duration: This authorization shall become effective immediately and shall remain in effect until _____(date), or for one year.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Print Name Relationship to Patient

Revocation: My written revocation will be effective upon receipt, but will not be effective to the extent the requester or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

This information is requested for the following purpose (Check all that apply):
_____Medical _____Legal _____Personal _____Other:_____

FAXED__ MAILED__ On_____ By_____