

PANIOLO PEDIATRIC AND FAMILY MEDICINE INC.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

This form permits _____ Phone#: _____
address: _____ Fax#: _____
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: _____ mm/dd/yyyy Main Contact Number: (____) _____
□ 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.

PANIOLO PEDIATRIC AND FAMILY MEDICINE INC
JON ISHII, MD, RACHELL MALAMED, APRN
P.O. BOX 6149 KAMUELA, HI 96743
75-170 HUALALAI ROAD SUITE D-214, KAILUA KONA 96740
PHONE# (808)325-5805 FAX#: (808)657-4796
WWW.PANIOLO.HEALTH

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: _____ type Records from: _____ mm/dd/yyyy to _____ 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: _____
