Medical Records Release

HIPAA Compliant Authorization for the Release of Patient Information Pursuant to 45 CFR 164.312(d)

Patient Name:	Previous Name (if applicable):
Date of Birth:	Daytime Phone:

I request and authorize Kahuku Medical Center to: ☐ **Release To** ☐ **Obtain From**

Name:		Phone:
Address:		Fax:
City:	State:	Zip Code:

You may use or disclose the following Private Healthcare Information (*check all that apply*):

Patients who request more than the last 2 years of their records may be charged a service fee. All payments are required prior to copying. All records are burned to a CD, faxed, or e-mailed. If paper copies are requested, additional charges may apply.

- ☐ ED Records
- ☐ Labs / Pathology
- ☐ X-rays / Diagnostics
- ☐ Immunizations
- ☐ Patient Visit Summary
- ☐ Most Recent Specialist(s) Visit
- ☐ History and Physical Report
- ☐ Clinic Visit Notes
- ☐ All Records
- ☐ Billing Records

Other:_____ Time Frame Requested:_____

Reason for Authorization (*check one*): ☐ At the request of the individual ☐ Other:_____

Expiration: ☐ Date:_____ **OR** ☐ One Time Release

- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment, or health care operations. I may inspect or copy any information used/disclosed under this authorization. I have authorized Kahuku Medical Center to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original.
- I understand that I may revoke this authorization in writing at any time to Kahuku Medical Center, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above.

Specific Authorization

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information unless I have marked NO and initialed it.

☐ Yes ☐ No Initials: _____

_____ Signature/Legally Responsible Party

_____ Relationship to Patient

_____ Date