



**Hawaii Women's Healthcare**  
*Comprehensive Care in Obstetrics and Gynecology*

Cheryl Lynn T. Rudy, M.D.  
 Cheryl L. Leialoha, M.D.  
 Angel M. Willey, M.D.  
 Erin C. Gertz, M.D.

## Authorization for Release of Medical Information

This form may be used to request a copy or a release of your patient information to a person or entity designated by you.

I hereby authorize Hawaii Women's Healthcare LLC, located at 1319 Punahou Street, Suite 760, Honolulu, HI 96826 to use or disclose my medical information as described below. I understand that this authorization is voluntary and that Hawaii Women's Healthcare LLC, will not withhold treatment if I refuse to sign this authorization.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other Names I May Be Known By: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_

This authorization covers the services provided during the period of \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.

I would like to request a **Copy** or a **Release** of the following information. Information to be disclosed (Check All That Apply):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> History & Physical Exam      | <input type="checkbox"/> Progress Notes       | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Lab Test Results             | <input type="checkbox"/> X-ray Report Results | <input type="checkbox"/> Surgery Reports      |
| <input type="checkbox"/> Pregnancy Records            | <input type="checkbox"/> Billing Records      | <input type="checkbox"/> All Records          |
| <input type="checkbox"/> Other (please specify) _____ |   |   |

1. My initials specifically authorize the release of any of the following kinds of information that are or may be in my record: (Note: We will not release your records if they contain any of the following unless initialed by you).

Initials: \_\_\_\_\_ AIDS or HIV or venereal disease

Initials: \_\_\_\_\_ Treatment of substance abuse

Initials: \_\_\_\_\_ Mental Health (including medications)/psychiatric services

2. This information is to be disclosed for the purposes of:
  - Continuing Health Care     Insurance     Legal Purposes
  - Other (please specify) \_\_\_\_\_
3. The information is to be picked up or mailed to:
  - Name: \_\_\_\_\_
  - To be picked up on (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_
  - Address: \_\_\_\_\_  
City, State and Zip code: \_\_\_\_\_
  - Telephone (for contact purposes): \_\_\_\_\_
4. I understand that if the person or entity I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. Hawaii Women's Healthcare LLC, its physicians, employees, and agents are released from any legal responsibility or liability for releasing the requested information as authorized.
6. My initials indicate I have read and agree to the following:
  - a. Initials: \_\_\_\_\_ I understand that this authorization will expire 1 year from the date signed below or upon the following event or condition (please describe):  
\_\_\_\_\_ unless revoked earlier.
  - b. Initials: \_\_\_\_\_ I understand that I may revoke (or cancel) this authorization at any time by notifying Hawaii Women's Healthcare LLC, in writing. I also understand that revoking this authorization will not apply to any information released by Hawaii Women's Healthcare LLC, before they received my written revocation.
  - c. Initials: \_\_\_\_\_ I understand that Hawaii Women's Healthcare, LLC reserves the right to collect reasonable fees for the copies I have requested.

(Hawaii Women's Healthcare LLC, does not accept incomplete or blank, signed forms.  
Form MUST BE COMPLETED before signing)

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by someone other than the patient, please describe your authority to act on behalf of the Patient: (e.g., parent, designated power of attorney) \_\_\_\_\_

Office use only:    ID Check: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Released by: \_\_\_\_\_ Date: \_\_\_\_\_