Hawaii Women's Healthcare
Comprehensive Care in Obstetrics and Gynecology

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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):

- ☐ History & Physical Exam
- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Lab Test Results
- ☐ X-ray Report Results
- ☐ Surgery Reports
- ☐ Pregnancy Records
- ☐ Billing Records
- ☐ All Records
- ☐ 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: _____