Aloha Nui DPC, LLC.
69 Lanihuli St. Hilo, HI 96720
808.961.1400 / 808.961.1300 (fax)

Medical Record Release Form

Client Information

Last Name:_____ First Name:_____ Middle:_____

AKA:_____ SSN:_____ DOB:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

I hereby authorize: _____

whose address is: _____

and telephone/fax number is: _____

to release my medical information to:

Aloha Nui DPC, LLC
69 Lanihuli Street Hilo, HI 96720
Phone: (808) 961-1400 Fax: (808) 961-1300

For the purpose of: (please mark all that apply)

☐ Changing Physicians ☐ Consultation ☐ Work ☐ Other:_____
☐ Continuation of Care ☐ Legal ☐ School _____

This authorization to disclose PROTECTED HEALTH INFORMATION (PHI) is voluntary. Treatment, payment or eligibility for benefits will not be affected if you do not sign this authorization. Disclosure of a person's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosed pursuant to the authorization may be disclosed by the recipient and no longer protected by Hawaii or Federal law.

1. This authorization will expire 1 year from date of signing.
2. I understand that the authorized information to be released may be subject to re-disclosure by the recipient and may not be covered under Federal Privacy Laws.
3. I have the right to revoke this authorization at *any* time.
4. I understand that revoking of this authorization must be submitted to this office in writing and will be effective immediately.
5. I understand that the revocation does not pertain to information previously released **prior** to notification.
6. I understand that this authorization is to be used to obtain and/or disclose PHI.
7. I understand I have the right to refuse to sign this form.

_____ _____

Last Name (Printed) First Name (Printed) Signature Date

STAFF ONLY

Authorized information to be released :

☐ History and Physical Exam ☐ Lab Reports (*including Pathology/Cytology reports*) _____
☐ Clinical Notes_____ ☐ Imaging Reports *(including Mammo/DEXA reports)* _____
☐ HIV/AIDS Related Information ☐ Substance Abuse ☐ Immunization Record
☐ Complete Medical Record ☐ Other: _____
☐ Consults ☐ Mental Health