**MAUI HEALTH SYSTEM**
Community hospitals affiliated with KAISER PERMANENTE®

# Authorization for Release of Protected Health Information

Patient Name: _____

MRN: _____ *DOB: _____

SSN (last 4 digits only): _____

**Note: Fees may apply to certain requests**

*I hereby authorize Maui Health System, on behalf of ☐ Maui Memorial Medical Center ☐ Kula Hospital ☐ Lanai Community Hospital

*To disclose the following information on the above named individual::

☐ Both Hospital and Clinic Records ☐ Clinic Records ☐ Hospital Records
☐ Records of Specific Provider: _____ or Dept._____
☐ X-Ray Films/Images ☐ X-Ray Report/Results ☐ Lab Results ☐ Immunizations
☐ Other (please specify: _____

*Release to: ☐ Maui Health System Attention: _____
(KP Provider or Clinic Department)

☐ Patient ☐ Physician, Other Person or Institution: _____
Address: _____
City: _____ State:_____ Zip Code:_____

*For the purpose of:

☐ At the Request of the Individual ☐ Legal Purposes ☐ Insurance ☐ School
☐ Continuing Care/Treatment ☐ Other: _____

Record format:
Unless otherwise indicated, medical records will be sent by electronic media.

☐ Paper ☐ CD ☐ Flash Drive ☐ Email address: _____

_____ (initials) **I agree to the disclosure of the following information should it be contained in my record: alcohol/drug dependency treatment records.**

***DURATION: Unless a different date is specified here _____ (date) this authorization shall remain in effect for one year from date of signature.**

**REVOCATION: I can revoke this authorization by submitting a letter to Health Information Management at** 221 Mahalani Street Wailuku, Hawaii 96793. **A revocation will not affect information disclosed prior to receipt of the revocation.**

**REDISCLOSURE: Information released under this authorization may be re-released by the recipient and no longer protected under federal privacy rules.**

**I understand that** Maui Health System **may not condition my treatment, payment, enrollment or eligibility for benefits on providing or refusing to provide this authorization, except for (i) research related treatment, (ii) health care provided solely for disclosure to a third party, or (iii) health plan initial enrollment/eligibility determinations, risk rating or underwriting.**
**I understand I have a right to receive a copy of this authorization.**

***Date:** _____ ***Signature:** _____ ***Print Name:** _____

**If signed by someone other than the patient or parent of a minor child, please indicate relationship. Submit documents to show authority to request information on the patient.**

***Relationship to Patient:** _____ **Phone Number: (_____)_____**

*Items that MUST be completed for authorization to be valid