MAIKA'I HEALTH CORPORATION

MEDICAL RELEASE FORM (INCOMING)

Patient Name (Print)	SS or Health Record Number	Patient DOB
_____	_____	____/____/____

_____ (*initial*) **I AUTHORIZE:**

Name of Sending Person/Organization: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____ Email: _____

TO RELEASE TO:

Maika'i Health Corporation
ATTN: Patient Services
670 Ponahawai Street, Suite 206
Hilo, HI 96720

Phone: (808) 333-3420
Secure Fax: (808) 333-3421
Secure Email: patientservices@maikaihealth.org

Please identify the information to be released:

- ☐ Please release my entire record
  -OR-
- ☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):
  - ☐ Problem list
  - ☐ Medication list
  - ☐ List of allergies
  - ☐ Immunization records
  - ☐ Most recent history and physical
  - ☐ Most recent discharge summary
  - ☐ Lab results (please describe the dates or types of lab tests you would like disclosed):_____
    _____
  - ☐ X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
    _____
  - ☐ Consultation reports (please supply doctors' names): _____
  - ☐ Other (please describe): _____

Please *initial* each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and /or treatment for alcohol and drug abuse.

_____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on (insert date or event):_____. If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ ____/____/____
Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

_____ ____/____/____
Witness Signature Date

Distribution of copies: original to practice, copy to patient, copy to accompany information released