MAUI LANI
PHYSICIANS & SURGEONS LLC

Authorization for: ____to Use or Disclose My Health Information

Patient Name:____________________________________DOB: _______/______/_____________
Also Known As:___________________________________*SSN:_-________-_______________
Phone #: (____)_______-_______*All items listed with asterisk are optional.

YOU MAY DISCLOSE THE FOLLOWING HEALTHCARE INFORMATION (check all that apply):

- All my health information maintained by ________________________. I understand that the records may be voluminous and I agree to pay all reasonable charges.
- All my health information maintained by the following physician(s):____
- My health information relating to the following treatment or condition:______________________________________
- My health information for the date(s):____
- Other:____

YOU MAY DISCLOSE THIS HEALTHCARE INFORMATION TO:

Mauilani Physicians & Surgeons, LLC
165 Ma`a st. Kahului, HI 96732
Ph: (808)446-7120
Fax: (808)446-7121

PURPOSE FOR DISCLOSURE (check all that apply):

- Changing Physicians • continuing Health Care, appointment date:_________________________
- School • Insurance • Legal • Workers Compensation • Consultation/Second Opinion
- Other (specify):____

Personal request for records fee: $15.00 plus tax per chart request, for the first 25 pgs., and $0.20 per page thereafter. Records cannot be copied until receipt of this prepayment. Postage is an additional charge. Please make checks payable to:* ***Maui Lani Physicians and Surgeons, LLC**.* Any request for records will take 5 to 7 working days after the receipt of authorization and/or prepayment.

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form: To take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by ***Maui Lani Physicians and Surgeons, LLC*** based upon this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance. For questions on how to revoke this form please contact us in writing or by phone.

Once this office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. This authorization will expire in 60 days from date of signature. A fax or copy of this authorization may be used as an original.

____   ____________________________________
Patient or legally authorized individual signature   Date

____   ____________________________________
Printed Name   Relationship to patient if signed on behalf of patient

A Modern Approach to Surgical Medicine and Women's Healthcare.