KOHALA COAST URGENT CARE & MOBILE HEALTH
62-100 KAUNAOA DRIVE, KAMUELA, HI 96743
PH: (808) 880-3211 FAX: (808) 475-0061

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize * **__KOHALA COAST URGENT CARE, LLC__** to release/obtain the protected health information of

*Patient Name: _____ Birthdate: _____

Address: _____ PhoneNo.:_____

*FROM/ TO Name or Institution: _____

Address: _____ City, State, Zip: _____

Phone No.: _____ Fax No.: _____

*Information to be disclosed:

Date(s) of Service:_____ (We are unable to process requests for future dates)

Progress Note(s)
IMAGING/EMG/MRI Report(s)
Entire Record
Billing Record(s)
OtherPleaseSpecify_____

*Purposes for the Use and/or Disclosure:

At the request of individual
Legal Purposes
DISABILITY
Physician follow –up
COREO/CPC+ –
PREVENTATIVE HEALTH MEASURES
Other:_____

***Unless otherwise revoked, this authorization will expire on the following date or event:_____.**
If a date or event is not specified, this authorization will expire one year from my date of signature below.

I understand that I may revoke this authorization at any time by notifying Kohala Coast Urgent Care, LLC, in writing, of my revocation. I understand that the revocation will not apply to any information that was already released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no-longer be protected under the federal privacy regulations.

I hereby release Kohala Coast Urgent Care, LLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or any professional opinions, finding, or recommendations as contained in the records released to or by Kohala Coast Urgent Care, LLC.

*Signature:_____ *Print Name:_____DATE: _____

*Relationship to Patient:_____ *Date:_____

***Items that MUST be completed for authorization to be valid.**

REV 03/25/2023