1281 South King Street
Honolulu, Hawaii 96814
808-593-8866

American Specialty Health Medical Release (HIPAA Compliant)

Patient:

Date of Birth:

MEDICAL SERVICE PROVIDER: The following service provider is authorized to provide medical records and disclose patient identifiable health information:

Thai Issan Therapeutic LLC.

The above named Service Provider is authorized to discuss my medical treatment and health information with my Health Care Provider, ___________________________________ , my Physician, **______________________, MD** as well as **American Specialty Health** strictly for the purpose of facilitating my ongoing Treatment Plan and the associated Billing for Services Provided for the above named Client.

The above named health provider is **NOT** authorized to discuss my medical treatment or health information with any other third party without my express written permission

MEDICAL RECORDS TO BE PROVIDED:

Prescription, Diagnosis and appropriate ICD-9 or ICD 10 Codes to be used strictly for the purpose of billing my Health Care Provider and or American Specialty Health

PROVIDE MEDICAL RECORDS TO:

Thai Issan Therapeutic LLC. 1281 South King Street, Honolulu, Hawaii 96814

PURPOSE: The patient identifiable health information received pursuant to this release authorization is to be used strictly for the following purposes.

American Specialty Health claims for Services Provided under my current Health Care Plan.

RIGHT OF REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to all parties having access to my personal medical information. Such revocation will not apply to records and information that have already been provided.

EXPIRATION: Unless earlier revoked, this authorization will expire one year after the date of this release or upon the completion of my claims relating to the above incident, whichever is later.

PATIENT RIGHTS: I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect and amend my medical records as provided in 45 CFR 164.526. I have the right to an accounting of the use and disclosure ofmy health information to any third party as provided in CFR 164.528. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization or my signing this release authorization.

RE-DISCLOSURE: I understand that there is a potential for unauthorized re-disclosure of the information and that the re-disclosed information may not be protected by federal confidentiality rules.

PHOTOCOPIES OF THIS RELEASE ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

DATE: BY: ____________________________________

(Printed Name)