Maui Cardiology, Ltd.

James E. Muto, M.D., F.A.C.C.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I authorize*_____to release the protected health information of the following:

*Patient Name:_____

Date of Birth:_____ SSN:_____

Address:_____

Phone: (_____) _____ - _____

To: *Name of Recipient:_____

Address:_____

Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

*Information to be disclosed: Date(s) of Service:_____ ____Entire Medical Record ____Medical Bills ____Other: _____	Purpose of Use and/or Disclosure: ____Legal Purposes ____At Request of Patient ____Other:_____

____(initial) I agree to the release of the following information should it be contained in my medical records:

Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex or HIV, alcohol and/or drug abuse treatment, or behavioral or mental health services (Unless I specifically agree, the information will not be disclosed).

*Unless otherwise revoked, this authorization will expire on the following date or event:

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_____. If a date or event is not specified, this authorization will expire one year from my date of signature below.

A reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

This authorization is voluntary. I understand that the above-named health care provider(s) or health plan(s) will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed by law.

I understand that I may revoke this authorization at any time by notifying the above-named provider(s) and/or health plan(s), in writing, of my revocation. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization and there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the right to contest a claim under my policy or my policy itself.

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 release the above-named health care provider from all liability and claims whatsoever pertaining to the disclosure of information as contained in the records released pursuant to this authorization.

*Requestor's Signature:_____

*Printed Name:_____

Relationship to Patient:_____

(Complete only if requestor is not patient. Must be legal guardian or have Power of Attorney form in file.)

*Date:_____

***Items must be completed for authorization to be valid.**