Maui Urology LLC

Dr. Soren Carlsen

(808) 242-8765 Office
(808) 242-8769 Fax

1883 Mill St, Suite A
Wailuku, Hawaii 96793

www.MauiUrology.com

AUTHORIZATION FOR MAUI UROLOGY LLC TO USE OR DISCLOSE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security # (optional): _____

I request and authorize: _____

_____

_____

_____

To release healthcare information of the patient named above to:

Maui Urology, LLC
1883 Mill Street, Suite 201
Wailuku, Hawaii 96793
Phone: (808) 242-8765
Fax: (808) 242-8769

This request and authorization applies to:

☐ Date(s) treatment was received: _____

☐ Consultation Report	☐ Laboratory Report	☐ Radiology
☐ Discharge Summary	☐ Operative Report	☐ Test Results
☐ Emergency Room Report	☐ Pathology Report	☐ History and Physical
☐ Other_____		

Purpose of Release:

☐ Continuing/Transfer of Care ☐ Insurance ☐ Litigation ☐ Personal Use ☐ Other_____

This authorization expires on the following date, event or condition: _____.
If I do not specify any expiration date, event or condition, this authorization will expire in one year.
Except to the extent that action has already been taken in reliance upon this authorization. I understand that I may revoke this authorization at any time by giving a written notice to: Maui Urology, LLC, 1883 Mill Street, Suite A, Wailuku, Hawaii 96793

Statement of Authorization:

- I understand that, except for research related treatment, Maui Urology, LLC, 1883 Mill Street, Suite A, Wailuku, Hawaii 96793 will not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Health Information Services (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

***Pt. or legally authorized individual signature:** _____**Date Signed:** _____
*Under HIPAA you can be charged a "reasonable" fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason.

FOR MAUI UROLOGY, LLC USE ONLY

Medical records requested by: _____ Date: _____