MMG MR#: ____-____-____-__ W/U/L

Maui Medical Group, Inc.

Health Care Excellence For Maui Since 1961

Authorization for Maui Medical Group 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 Maui Medical Group. I understand that the records may be voluminous and I agree to pay all reasonable charges associated with PCSC providing copies of the records.

☐ All my health information maintained by the following physicians: **Soren Carlsen, William Bodenstab, Frank Celigoj**

☐ My health information relating to the following treatment or condition: Any and all urologic conditions

☐ My health information for the date(s): **2013 to current date**

☐ Other:**All urology records including progress notes, operative and procedure reports**, Urinalyses, urine cultures, PSA, Testosterone, genitourinary pathology reports, BMP, CMP, **CT, MRI, xray and Ultrasound** of abdomen, pelvis, genitals

It is Maui Medical Group's policy to release only 1 year of records unless specifically stated.

YOU MAY DISCLOSE THIS HEALTHCARE INFORMATION TO:

Name (or title) and organization: **Soren Carlsen, MD. and/or Maui Urology, LLC**, _____

Address:**1883 Mill St, Suite A** City: **Wailuku** State: **HI** Zip:**96793**

PURPOSE FOR DISCLOSURE (check all that apply):

☐ Changing Physicians ☐ Continuing Health Care, appointment date:_____

☐ School ☐ Insurance ☐ Legal ☐ Workers Compensation ☐ Consultation/Second Opinion

☐ Other (specify): **Transferring urology care to a Maui Urology – need records immediately**

Personal request for records fee: $15.60 plus tax totaling $16.25 per chart request, for the first 20 pgs., and $0.30 per page there after.* *$16.25 is an upfront payment*** *and records can not be copied until receipt of this prepayment. Postage is an additional charge. Please make checks payable to:* ***Professional Collection Services Company (PCSC)****, 2180 Main Street, Wailuku, HI 96793 Phone 243-2307 Fax 243-2341**

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 Medical Group or PCSC 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 PCSC 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 90 days from date of signature. A fax or copy of this authorization may be used as an original.

X_____ X_____

Patient or legally authorized individual signature — Date

X_____ _____

Printed Name if signed on behalf of the patient — Relationship (parent, legal guardian, personal representative, etc.)