Rheumatology Associates of Maui, LLC
161 Wailea Ike Pl, A104
Kihei, HI 96753
Ph: 808 757-6106
Fax: 866 397 -2741

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Date of Birth: _____ Contact Phone number: _____

I REQUEST AND AUTHORIZE: **Rheumatology Associates of Maui LLC** to process the following request regarding my medical records:

□ OBTAIN From □ SEND To □ DISCLOSE to SELF

Name*: _____
Address: _____
City: _____State: _____ Zip: _____
Phone*: _____ Fax: _____
*Information REQUIRED to complete request

I AUTHORIZE the following information to be disclosed: (Check all that apply)

□ Entire Chart (Outpatient)
□ Imaging
□ Billing Records
□ Other: _____

Additional Information:
_____

This authorization expires on _____ or, 90 days from the date of signature. I understand I have the right to revoke this consent at any time in writing except to the extent that the information has already been released.

_____ _____
Signature Date

*Section 164.506 © (1) of the HIPAA Privacy Regulation states a covered entity is not required to obtain a patient authorization to use or disclose patient health information for treatment, payment, or its own health care operations.

HIV ONLY: I understand specific reference may be made to HIV testing and results, and any related diagnosis and medical condition(s) which may be recorded in my health records. I hereby authorize the release of any HIV antibody test results and related information. Exchange of information ensures continuity of care between providers. By not sharing information my heath care could be compromised. Only that information which I authorize will be released.

_____ _____
Signature Date