Pukalani Family Practice

SERVING YOUR 'OHANA WITH ALOHA

Re: Patient Name: _____

Date of Birth: _____

Social Security: _____

I hereby authorize **Pukalani Family Practice**
to **RELEASE**
the following information to:

_____
_____
_____
_____

Any and all information regarding the above described individual including, but not limited to, all medical records; other records; notes; incidence, occurrence, or other reports; test results; referrals; memoranda; correspondence; photographs; x-ray, CT and MRI films; bills, invoices, accountings, statements of charges, and all insurance-related documents ("Information").

This authorization includes, but is not limited to, any and all Information relating in any way to the diagnosis, treatment, referral, or rehabilitation rendered to individual pertaining to (1) alcohol, drug, or other substance use or abuse; (2) mental health or mental illness; (3) sexually transmitted diseases including human immunodeficiency virus ("HIV") infection, acquired immune deficiency-syndrome ("AIDS"), or AIDS-related complex ("ARC"). I understand that specific consent may be required to release such information, and hereby give such specific consent. If applicable, I hereby waive all requirements of any and all state and federal laws and regulations restricting the release, use and dissemination of the Information.

A photocopy of this Authorization is valid as an original.

PRINT NAME_____ DATE_____

SIGNATURE_____

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