Requesting provider:_____

Processed by: _____

DOS Ref: _____

Pukalani Family Practice

Rob Mastroianni MD

Tel: 808 573 8900 Fax: 808 573 7505
Pukalani Square
81 Makawao Ave Ste 100, Makawao, HI 96768

Re: Patient Name: _____

Date of Birth: _____

I hereby authorize:

Doctor	Tel #	Fax #
_____	/	/ _____
_____	/	/ _____
_____	/	/ _____
_____	/	/ _____
_____	/	/ _____

to release the following information to: **Pukalani Family Practice "Continued Care"**

****In order to conserve time and paper please send only what is requested below.****

*Information to be disclosed:		*Purposes of Use and/or Disclosure:
__ Current Medications	__ All Pap/LEEP/Colposcopy	
__ Current Labs/Pathology	__ Mammo	__Legal purposes
__ All Radiology Records	__ Colonoscopy	
__ Immunizations	__ Diabetic Eye Exam	__At request of patient
__ Last 3 Progress Notes	__ Annual Physical	
__ All Specialist Consults		__Continuity of Care
Other: Please specify		__Other:
_____		
_____		

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 the 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 I herby 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.

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.

This release is valid for one Year from the date signed. I understand that I may revoke this authorization at any time by notifying the above named provider(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 itself.

A photocopy of this Authorization is valid as an original.

_____ _____

PRINT NAME DATE

SIGNATURE

Name: _____

REQUESTING	DOCTOR	FACILITY/LOCATION	PHONE	FAX
PREVIOUS PCP				
SPECIALIST **LIST TYPE*	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____
PAP				
MAMMO				
COLO				
IMAGING				
LAB				
MENTAL HEALTH	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____
OTHER	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____	1. _____ 2. _____