



# Pukalani Family Practice

SERVING YOUR 'OHANA WITH ALOHA

Re: Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security: \_\_\_\_\_

Requesting provider: \_\_\_\_\_

Processed by: \_\_\_\_\_

DOS Ref: \_\_\_\_\_

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.\*\***

<p><b>*Information to be disclosed:</b></p> <p><input type="checkbox"/> Current Medications</p> <p><input type="checkbox"/> Current Labs/Pathology</p> <p><input type="checkbox"/> All Radiology Records</p> <p><input type="checkbox"/> Immunizations</p> <p><input type="checkbox"/> Last 3 Progress Notes</p> <p><input type="checkbox"/> All Specialist Consults</p> <p>Other: Please specify _____</p>	<p><b>*Purposes of Use and/or Disclosure:</b></p> <p><input type="checkbox"/> Legal purposes</p> <p><input type="checkbox"/> At request of patient</p> <p><input type="checkbox"/> Continuity of Care</p> <p><input type="checkbox"/> Other: _____</p>
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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 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.

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

**ROB MASTROIANNI MD • LIAT MILLER APRN • ANN CRADDOCK APRN**

81 MAKAWAO AVE, STE. 100 • MAKAWAO, HI 96768

TEL: (808) 573-8900 FAX: (808) 573-7505

*www.PukalaniFamilyPractice.com*



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SERVING YOUR 'OHANA WITH ALOHA

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

REQUESTING	DOCTOR	FACILITY	PHONE	FAX
PREVIOUS PCP				
SPECIALIST	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. _____

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