Office use only: ID Check: _____ MRN: _____
Source: _____ Released By: _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize this provider/facility STRAUB CLINIC & HOSPITAL
located at the following address 888 S. King St. Honolulu, Hawaii 96813 Attn: Medical Reports
to use or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and that this facility will not withhold treatment if I refuse to sign this authorization.

Patient Name: X _____ Date of Birth: X _____ SSN: X _____
Other names I may be known by: _____
Address: X _____
Telephone: Work: _____ Home: _____ Other: _____

X This authorization covers the services provided during the period of __/__/__ (mm/dd/yy) to __/__/__ (mm/dd/yy)

X **I would like to** ☐ **Review** ☒ **Copy** ☐ **Request a release of the following information: (check as many as apply)**

- ☐ History and Physical Examination (clinic)
- ☐ History and Physical Report (hospital)
- ☐ Laboratory tests results
- ☐ AIDS or HIV infection/HIV Testing
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Mental health or psychiatric services (*excluding psychotherapy notes*)
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Pathology reports
- ☐ ER Records
- ☐ Clinic Visit Notes
- ☐ X-ray reports results
- ☐ X-ray Films
- ☐ Consultation Reports
- ☐ Surgery reports
- ☐ Billing Records
- ☐ Photographs, videotapes, digital or other images
- ☐ Other (please specify) _____

Note: Release of Psychotherapy Notes, as defined by HIPAA Regulations, requires a separate authorization

1. My initials specifically authorize the release of any of the following kinds of information that are or may be in my record **(Note: we will not release your records if they contain any of the following unless initialed by you):**

_____ AIDS or HIV infection or venereal disease _____ Treatment of alcohol or drug abuse _____ Mental health(including medications)/psychiatric services

2. This information is to be disclosed for the purpose of: ☐ Continuing Health Care ☒ Insurance ☐ Legal Purposes
   ☐ Other (specify): _____
3. Information to be released or sent to: EXAMONE/APS
   Name: 800 NW CHIPMAN RD, SUITE 5900 Telephone: _____
   Address: P.O. BOX 2340 City LEES SUMMIT, MO 64063-1149 State _____ Zip _____
4. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. This facility, its employees, officers, and physicians are released from any legal responsibility or liability for releasing the requested information as authorized.
6. My initials indicate I have read and agree to the following:
   a. **Initials:** _____ I understand that this authorization will expire 1 year from the date signed below or upon the following event or condition _____ unless revoked earlier.
   b. **Initials:** _____ I understand that I may revoke this authorization at any time by notifying this facility in writing. I also understand that revoking this authorization will not apply to any information released by this facility before they received the revocation. (See our *Notice of Privacy Practices* for instructions)
   c. **Initials:** _____ I understand that the provider/facility reserves the right to collect reasonable fees for the copies I have requested.

(Form MUST be completed before signing)

Signature: X _____ Print Name: X _____ Date: X _____

If signed by someone other than the patient, please describe your authority to act on behalf of the Patient:

_____

MAIL OR FAX TO: STRAUB CLINIC AND HOSPITAL, MEDICAL REPORTS DEPARTMENT,
888 So. King St., Honolulu, Hawaii 96813 FAX#: 808/522-3207

Straub
CLINIC & HOSPITAL
An affiliate of Hawaii Pacific Health

Form# *rev date*