Authorization to Release Protected Health Information

Kapa'a Pediatrics, LLC - 4-1461 Kuhio Hwy. Kapa'a, HI 96746
P: (808) 634-8011 - Fax (844) 833-5037

Summarized Notice of the Uses and Disclosures of Protected Health Information

We are required by federal law to maintain the privacy of your Protected Health Information (PHI), and to provide you with notice of our legal duties and privacy practices regarding PHI. PHI is information that we keep in electronic or paper form, including demographic information collected from you and is created or received by us and relates to your past, present, or future payment for the health care services that we deliver to you, and that identifies you or which we believe can be used to identify you.

Patient Information	Patient Name:	DOB:
	Address: ____________________________________ City:__________________ State:____ Zip:________	Phone #:

Record Holder: *(Who has the information you want released?)*	☐ Kapa'a Pediatrics, LLC ☐ Kauai Medical Clinic 3-3420 Kuhio Hwy. Lihue, HI 96766
	☐ Other: __________________________ Phone: _____________ Fax:__________ Address/City/State/Zip: ____

Release Records to: *(Where do you want records sent?)*	☐ Hospital/Clinic/Person: _____________________ Phone: ________Fax:________ Address/City/State/Zip: ____
	☐ Kapa'a Pediatrics, LLC ☐ Kauai Medical Clinic 3-3420 Kuhio Hwy. Lihue, HI 96766

Health Information to be Released	☐ Routine Record Sets - For dates of service __________________ ☐ Vaccination Records ☐ Growth Charts ☐ Last Well Check Record ☐ Entire Health Record ☐ Other: __________________

Authorization of General Release of Information:

I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party. I understand this authorization may be revoked in writing at any time except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked this authorization will expire 12 months after the date of signing this form. I have the right to receive a copy of this authorization.

__________________________________ ___________________

Signature of Patient or Authorized Representative — Print Name

__________________________________ ___________________

Relationship to Patient — Date

Medical Record Fees: There is no charge for records to be sent to another health care provider. Records released directly to the patient or an authorized family member may be subject to charges; the first 20 pages are at no cost and after the 20th page there will be a charge of $0.25 per page.