AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name ____ Date of Birth __________________________

I hereby give authorization to ____ to release the Protected Health Information (PHI), including medical records, diagnosis, treatment, prognosis, and recommendations to:

Dr. Richard A. Ridao
At King Center Building
1451 South King Street, #309
Honolulu, HI 96814
Telephone (808) 593-2155 Fax (808) 593-2156
*Do not send CD or USB Flash Drive

Information to be released includes (check ALL that apply):

- ☐ Complete Medical Record
- ☐ Operative Reports
- ☐ Clinical Notes (examination notes)
- ☐ Laboratory Reports
- ☐ Consultation Reports
- ☐ Radiology Reports
- ☐ Other (describe): ____

Dates of Care: From _________________________________ To ____

The information authorized for release will be used for the following purposes: Continued of care

____

Please initial your choice here.

If PHI records requested include information relating to treatment of HIV/AIDS (initial EACH selection):

________ I authorize release ________ I do NOT authorize release of that portion of my PHI

If PHI records requested include information relating to treatment at a facility for alcohol or substance abuse:

________ I authorize release ________ I do NOT authorize release of that portion of my PHI

If PHI records requested include information relating to treatment at a mental health facility:

________ I authorize release ________ I do NOT authorize release of that portion of my PHI

This authorization expires on: ____________________ (date); or:

☐ upon release of the requested information; or:

☐ other (specify): ____

If no selection is made, this authorization will automatically expire one year after the date of signing.

- I understand that this authorization may be revoked at any time by my written notification. However, even if I do revoke authorization, I understand that my revocation will not affect any actions taken by my provider prior to their receiving the revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my intended treatment.

____ ___________________________

Signature of Patient or Authorized Personal Representative Date

____ ___________________________

Printed Name of Authorized Personal Representative* (if applicable) Relationship to Patient

* Attach Documentation of authorization Rev Jan2025