Aloha Pediatrics LLC Authorization for Use and Disclosure of Health Information

I hereby authorize the use or disclosure of my individually identifiable information as described below. I understand this authorization is voluntary.

Patient Name:_____ Date of Birth:_____
AKA:_____ Address:_____
Telephone: Work:_____ Home:_____ Mobile:_____

1. **Aloha Pediatrics/Dr. Jami Knox requests the following information from:_____**

This information is to be disclosed for the purpose of:
( ) Physician follow-up
( ) Insurance
( ) Legal Purpose
( ) Patient Request
( ) Other (specify): _____
_____

I request the following format:
( ) Review only ( ) Paper Copy
( ) Electronic Copy (non-encrypted)
( ) Submit to Another Provider:_____
Provider Address:_____
City:_____ State: _____ Zip:_____
Phone: _____
( ) Other (please specify): _____

2. Select from the following (check all that apply) for services during the period of:_____/_____/_____to_____/_____/_____

( ) Billing records	( ) History and Physical Examination	( ) Treadmill reports
( ) Complete Record	( ) Laboratory Reports	( ) Verification of Birth
( ) Consultation Reports	( ) Operative Reports	( ) X-Ray Reports
( ) Discharge Summary	( ) Pathology Reports	( ) X-Ray Images
( ) Echocardiogram Reports	( ) Photo/Video/Digital/Other images	( ) Other (please specify)_____
( ) EKG Reports	( ) Psychotherapy Notes	_____
( ) ER Reports	( ) Progress Notes	_____

3. Alcohol and/or Drug Abuse Records: The patient records and information of certain alcohol abuse and drug abuse programs are specifically protected under federal regulations and will not be released without my specific authorization. By initialing here _____, I hereby specifically authorize the facility to release any such information/records contained within my records.
4. I understand 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. The facility, its employees, officers and physicians are released from any legal responsibilities or liability for releasing the requested information as authorized.
6. My initials indicate that I have read and agree to the following:

a. Initials_____ I understand this authorization will expire six months from the date signed below or upon the following event or condition _____, unless revoked earlier.
b. Initials_____ I understand I may revoke this authorization at any time by notifying this office in writing. I also understand that revoking this authorization will not apply to any information already released by this office before they received the revocation. (See our Notice of Privacy Practices for instructions.)
c. Initials_____ I understand that the provider/office reserves the right to collect reasonable fees for the copies I have requested.

7. I hereby release Aloha Pediatrics LLC and its employees from all liability and all claims of any nature whatsoever pertaining to the use and disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Aloha Pediatrics LLC. I understand that Aloha Pediatric LLC is NOT responsible for lost or misplaced copies (paper, cd's, flash drives, etc.), and that it is my responsibility to handle them with care.
8. This authorization is voluntary. I understand that I can refuse to sign this authorization and Aloha Pediatrics LLC will not condition my treatment, payment, or enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: 1) research-related treatment, 2) health care provided solely for disclosure to a third party or 3) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

Signature:_____ Print Name:_____ Date:_____

Relationship to Patient:_____