Aloha Nui DPC, LLC. 69 Lanihuli St. Hilo, HI 96720 808.961.1400 / 808.961.1300 (fax)



Medical Record Release Form

Client Information							
Last Name:	First Nam	First Name:		Middle:			
AKA:							
Address:		City:		State:	Zip:		
Home Phone: ()	Ce	ell Phone: ()				
I hereby authorize:		whose address is					
and telephone/fax number is							
to release my medical inform	ation to:						
Name: Aloha Nui DPC, LLC	Address: <u>69 L</u>	<u>anihuli St. </u> Cit	ty: <u>Hilo</u>	_State:_ <u>HI</u>	Zip:_	96720	
Phone: (808) 961-1400	Fa	x: (808) <u>9</u>	61-1300				
For the purpose of: (please ma	ark all that apply)						
☐ Changing Physicians ☐	☐ Consultation ☐	Work [☐ Other:				
☐ Continuation of Care		School					
 This authorization will expire 1 year from date of signing. I understand that the authorized information to be released may be subject to re-disclosure by the recipient and may not be covered under Federal Privacy Laws. I have the right to revoke this authorization at <i>any</i> time. I understand that revoking of this authorization must be submitted to this office in writing and will be effective immediately. I understand that the revocation does not pertain to information previously released prior to notification. I understand that this authorization is to be used to obtain and/or disclose PHI. I understand I have the right to refuse to sign this form. 							
Last Name First Nam (Printed) (Printed)	me	Signatur	e	Da	ate		
STAFF ONLY							
Authorized information to be	released :						
☐ History and Physical Exam	☐ Lab Reports (ii	Lab Reports (including Pathology/Cytology rpts)					
☐ Clinical Notes	□ Imaging Repo	☐ Imaging Reports (including Mammo/DEXA rpts)					
☐ HIV/AIDS Related Information	on 🔲 Substance Abu	ıse □ Immu	nization Re	ecord			
☐ Complete Medical Record	□ Other:						
	☐ Consults	☐ Menta	l Health				