Hawai'i Pain Center
2226 Liliha Street, Suite 407, Honolulu, HI 96817
☎ 808-445-9172 🖷 808-445-9182

Authorization for Release of Protected Health Information

Patient_____DOB:_____

By signing this form, I authorize the use and disclosure of my protected health information to:

Hawaii Pain Center
2226 Liliha Street, Suite 407
Honolulu, HI 96817
Fax: 808-445-9182

OFFICE USE ONLY
Requested Information: □ ALL Records □ Consult / H&P □ Progress Notes / SOAP □ Operative / Procedure Reports □ Diagnostic / Imaging Reports □ Lab Results

I understand my health information is protected by Federal and State Law. I also understand I may revoke this authorization at any time in writing. Otherwise, the authorization will expire 12 months from the date of signature. I understand my records may contain information regarding the diagnosis or treatment of HIV, AIDS, or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released.

_____ _____

Signature Date