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

Authorization for Confidential Communication

I authorize Hawaii Pain Center to release my protected health information to:

Provider's Name:____________________Office Address:______________________

Provider's Name:____________________ Office Address:______________________

Provider's Name:____________________Office Address:______________________

Name:______________________________Relationship:________________________

Name:______________________________Relationship:________________________

Name:______________________________Relationship:________________________

If you do not want your protected health information released to anyone other than your referring provider, <u>leave blank and sign below</u>. A court order or a signed release from you will be required by anyone requesting your information that is not listed above. Please note that by accepting care from this specialty facility, your protected health information will be provided to your <u>referring provider</u> unless otherwise specified in writing.

_____________________ __________________ ________________
Name Signature Date