

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: _____ Date-of-Birth: _____

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