OAHU SPINE & REHAB
MEDICAL RECORD REQUEST OR ACCESS TO HEALTH INFORMATION

**** Email COMPLETED FORM To: info@oahuspineandrehab.com ****

I, (patient) _____ (DOB) _____, authorize (provider)_____
to use and/or disclose my health information as identified below to (name and address of recipient):

_____

_____

For the following purpose(s): (describe each purpose):

_____

_____

By checking the boxes below, I specifically authorize disclosure of the following health information and/or records, if such information and/or records exist:

☐ Send the entire medical record (all information)
☐ Clinician office chart notes
☐ Most recent two-year history
☐ Other: _____
☐ Most recent five-year history
☐ Laboratory reports
☐ Pathology reports

*The following items must be initialed to be included in the use or disclosure of other health information:

___ *HIV/AIDS related health information and/or records

___ *Mental Health information and/or records

___ *Genetic testing information and/or records

___ *Drug/alcohol diagnosis, treatment and/or referral information (federal law regulations require a description of how much and what kind of information is to be disclosed.

___ *Psychotherapy notes (if this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Oahu Spine & Rehab. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert date) _____

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so:

_____ _____

Signature of Individual or Individual's Legal Representative Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship of legal rep to individual

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