

Email completed Form E to Straub: Jennifer.oldershaw@straub.net and dora.sakata@straub.net

<b>Office use only:</b>	ID Check: _____	MRN: _____	Date: _____
	Source: _____	Released By: _____	

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize this provider/facility STRAUB OCCUPATIONAL HEALTH SERVICES

located at the following address 800 S KING ST 3RD FL, HONOLULU, HAWAII 96813

to use or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and that this facility will not withhold treatment if I refuse to sign this authorization.

Last 4 digits SS# \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **-SSN-** \_\_\_\_\_

Other names I may be known by: \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Home:** \_\_\_\_\_ **Other:** \_\_\_\_\_

This authorization covers the services provided during the period of \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm/dd/yy) (mm/dd/yy)

I would like to  Review  Copy  Request a release of the following information: (check as many as apply)

- |  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> History and Physical Examination (clinic)  | <input type="checkbox"/> Progress Notes                                   | <input checked="" type="checkbox"/> X-ray reports results |
| <input type="checkbox"/> History and Physical Report (hospital)  | <input type="checkbox"/> Discharge Summary                                | <input checked="" type="checkbox"/> X-ray Films           |
| <input checked="" type="checkbox"/> Laboratory tests results   | <input type="checkbox"/> Pathology reports                                | <input type="checkbox"/> Consultation Reports             |
| <input type="checkbox"/> AIDS or HIV infection/HIV Testing   | <input type="checkbox"/> ER Records                                       | <input type="checkbox"/> Surgery reports                  |
| <input type="checkbox"/> Treatment for alcohol and/or drug abuse   | <input type="checkbox"/> Clinic Visit Notes                               | <input type="checkbox"/> Billing Records                  |
| <input type="checkbox"/> Mental health or psychiatric services (excluding psychotherapy notes)                       | <input type="checkbox"/> Photographs, videotapes, digital or other images |   |
| <input checked="" type="checkbox"/> Other (please specify) <u>DRUG TESTING AND/OR BREATH ALCOHOL TESTING RESULTS</u> |   |   |

**Note:** Release of Psychotherapy Notes, as defined by HIPAA Regulations, requires a separate authorization

~~1. My initials specifically authorize the release of any of the following kinds of information that are or may be in my record—  
(Note: we will not release your records if they contain any of the following unless initialed by you):~~

~~AIDS or HIV infection or venereal disease      Treatment of alcohol or drug abuse      Mental health (including medications)/psychiatric services~~

2. This information is to be disclosed for the purpose of:  Continuing Health Care  Insurance  Legal Purposes  
 Other (specify): PRE/POST EMPLOYMENT, ANNUAL AND COMPANY REQUIRED TESTING(S)

3. Information to be released or sent to:  
Company Name/Academic Unit Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

4. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

5. This facility, its employees, officers, and physicians are released from any legal responsibility or liability for releasing the requested information as authorized.

6. My initials indicate I have read and agree to the following:

a. **Initials:** \_\_\_\_\_ I understand that this authorization will expire 1 year from the date signed below or upon the following event or condition \_\_\_\_\_ unless revoked earlier.

b. **Initials:** \_\_\_\_\_ I understand that I may revoke this authorization at any time by notifying this facility in writing. I also understand that revoking this authorization will not apply to any information released by this facility before they received the revocation. (See our *Notice of Privacy Practices* for instructions)

c. **Initials:** \_\_\_\_\_ I understand that the provider/facility reserves the right to collect reasonable fees for the copies I have requested.

*(Form MUST be completed before signing)*

**Signature:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by someone other than the patient, please describe your authority to act on behalf of the Patient: \_\_\_\_\_

MAIL OR FAX TO: STRAUB CLINIC AND HOSPITAL, MEDICAL REPORTS DEPARTMENT,  
888 So. King St., Honolulu, Hawaii 96813 FAX#: 808/522-3207

**HAWAII PACIFIC HEALTH** | **STRAUB MEDICAL CENTER**

ADDRESSOGRAPH: (Name / Life # / DOB / SS# / Age / Gender)