Consent to Release of Medical Information

Patient's Name:_____ DOB: _____

I authorize Hawaii Pacific Neuroscience to disclose/request my health information including copies of records as necessary to/from:

1. Any health insurance plan or company of billing service that provides insurance coverage for me for the purpose of payment of charges, as well as any workers' compensation, no fault or administrative proceeding for the purpose of evaluating my medical condition.
2. Any insurance company that provides liability insurance coverage for Hawaii Pacific Neuroscience to evaluate clinical performance.
3. Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other health providers for the purpose of continuity of care.
4. External sources (i.e. pharmacies), granting permission to the doctors and medical assistants view your prescription history.
5. Other organizations, permitting the release of medical data in order to adjudicate claims associated with the patient.

All medical information with no exceptions will be disclosed / requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 2 years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

_____ _____ _____

Patient or Guarantor (Print Name) Patient or Guarantor Signature Date