

# Maui LeiAloha OBGYN, LLC

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## Patient Authorization for Release of Health Records to External Parties

1. I authorize \_\_\_\_\_ to disclose information from the health records of: \_\_\_\_\_

Account #: \_\_\_\_\_ (patient) Date of Birth: \_\_\_\_\_

2. The information is to be disclosed to: Avani Lakhani, MD

Address : 4730 Univ Way NE Ste 104 PMB 5104

City, State, Zip: Seattle WA 98105

Contact Person: \_\_\_\_\_

Phone/Fax: Tel: (808) 244 0401 Fax: (888) 498 3453

I authorize this information to be disclosed in the following ways:

- Written/Photocopy/Paper       Verbal       Fax       Electronic Mail \*

Purpose of the disclosure: \_\_\_\_\_

3. Dates of Treatment: From: \_\_\_\_\_ To: \_\_\_\_\_

### Specific reports to be disclosed:

- Progress Notes       Laboratory Reports       Operative Reports  
 Discharge Summary       Radiology Reports       Consultation Reports  
 X-ray films or other images       Photographs/Videotapes       Records from other facilities  
 Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)  
 Other(Specify): \_\_\_\_\_

I give specific authorization to disclose the following information:

- HIV test results       Documentation of AIDS diagnosis  
 Drug and alcohol abuse treatment records       Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying UT Health Science Center in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time: \_\_\_\_\_

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

\_\_\_\_\_  
Signature of Patient (or Patient Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Patient Representative

\_\_\_\_\_  
Authority of Representative to Act for Patient  
(Relationship to Patient)

\* Need to ensure separate E-mail Authorization Agreement is signed.  
Note: Release of Psychotherapy notes requires a separate authorization.