AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION. DISCLOSING PROVIDER: INTEGRATED CARE

This form is being completed to authorize Integrated Care LLC to share your medical information with other healthcare providers, facilities, caregivers, or agencies involved in your care to support coordination, continuity, and appropriate treatment. Please complete all required fields, including your full name, date of birth, and contact information. Select who the information may be shared with, the specific records authorized for release, and the purpose of disclosure. Review any sections requiring special consent carefully, then sign and date the form to confirm your authorization. If a parent, guardian, or legal representative is signing on your behalf, indicate this in the designated area

Patient Full Name, First, Last

_____

Patient Phone #

_____

Patient Date of Birth

_____

Social Security #

_____

I authorize Integrated Care and staff/providers to release my medical information.
FROM
Integrated Care LLC
Address: 5922 Gannet Ave, Ewa Beach, Hawaii 96706
Phone: 808-738-7671
Fax: 689-212-0762
Email: patientsupport@integrated-care.org

Release records to (Check all that apply

- ☐ Individual Provider
- ☐ Clinic / Medical Facility
- ☐ Family Member / Caregiver
- ☐ Case Management Agency
- ☐ Care Home / Assisted Living Facility: Select this option if you currently reside in or receive services from a care home or assisted living facility.

Facilities listed below, if applicable, for medical records and clinical staff and/or case management agency.

- ☐ Arcadia Retirement Residence 1434 Punahou Street | Honolulu, HI 96822
- ☐ Mental Health Kokua | 680 Iwilei Road, Sute 600, Honolulu, HI 96817
- ☐ Leahi Hospital | 3675 Kilauea Ave, Honolulu, HI 96816 ·
- ☐ Other (Not Listed): If the recipient is not listed above, select this option and complete the TO section below with the name, address, and contact information of the individual or organization.

Release records to: (Name, Address, Email, Phone #, Fax #)

_____

RECORDS AUTHORIZED TO BE RELEASED (Note: Please see "Disclosures Requiring Special Consent" section below)

- ☐ All Records
- ☐ Visit Notes
- ☐ Ultrasound/Imaging Reports
- ☐ Operative Reports
- ☐ IVF Cycle Reports
- ☐ Ovulation Induction/IUI Notes
- ☐ Lab Reports

Other

_____

This information will be used for the purpose of (Optional):

- ☐ Primary Care Provider
- ☐ Benefits Application
- ☐ Disability Determination
- ☐ Legal Representation
- ☐ Personal Use

Other

_____

I UNDERSTAND THAT:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- I am entitled to receive a copy of this authorization.
- Federal privacy regulations will no longer apply to the information disclosed.
- A copy of this authorization may be utilized with the same effectiveness as an original.

EXPIRATION DATE:

This authorization is effective for the duration while I'm under care from the date signed below unless otherwise indicated.
I understand that I can revoke this authorization at any time by contacting Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC in writing.
I understand that revoking this authorization will not affect disclosures already made or actions taken before the revocation is received.
Use paragraph blocks to write a description, set of instructions, or provide supplemental information for your patients to help complete the form.

DISCLOSURES REQUIRING SPECIAL CONSENT My signature below specifically authorizes the release of health information relating to testing, diagnosis, and treatment for (Optional):

- [ ] Not Applicable
- [ ] Developmental Disabilities
- [ ] Sexually Transmitted Diseases
- [ ] Alcohol / Drug Use

Please sign your name below *

Signature

Date

- [ ] I am the parent/guardian of this patient