AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO INTEGRATED CARE

This form is being completed to authorize the release of your health information to Integrated Care LLC so that your care team can coordinate treatment, communicate with other providers, and ensure continuity of care. Please complete all required fields accurately, including your full name, date of birth, and contact information. If you are a legal Power of Attorney or court-appointed guardian signing on behalf of the member, print your full name in the designated section. Select the specific records and time period to be released, review the authorization statements carefully, then sign and date the form to confirm your consent

Full Name

_____

Social Security #

_____

Date of Birth

_____

Email

_____

Phone #

_____

Address:

_____

Type full name if you are the legal Power of Attorney (POA) or court-appointed guardian authorized to sign on behalf of the member.

_____

I am requesting the release of my health information to Integrated Care LLC.
I understand that I am not required to sign this authorization and that my healthcare, benefits, or payment for care will not be affected if I choose not to sign. I understand that I am entitled to receive a copy of this authorization upon request.
I understand that once my information is disclosed under this authorization, federal privacy regulations may no longer protect the information. I also understand that a copy of this authorization is as valid as the original.
This authorization is effective from the date signed below and will remain in effect for the duration of my care with Integrated Care LLC, unless otherwise specified.
I understand that I may revoke this authorization at any time by submitting a written request to Integrated Care LLC and/or its subsidiary, Integrated Care Mental Health LLC. I understand that revocation will not apply to information already disclosed or actions already taken prior to receipt of the revocation request.

Release records to:
Integrated Care LLC
Address: 5922 Gannet Ave, Ewa Beach, Hawaii 96706
Phone: 808-738-7671
Fax: 689-212-0762
Email: patientsupport@integrated-care.org

From: Clinic

_____

From: Provider

_____

From: Address:

_____

From: Phone #

_____

From: Email Contact

_____

From: FAX # If Known

_____

Authorization to Release Health Information
I authorize the release of my health information to Integrated Care LLC and, when applicable, its subsidiary Integrated Care Mental Health LLC, for the purpose of care coordination, treatment, payment, and healthcare operations, as permitted by law.

Information to Be Released (Please select all that apply): If selecting **Entire Medical Record, please do not select any additional options. Choose only the categories of information you wish to authorize for release.** *(select one)*

- ◯ Entire medical record
- ◯ Primary care records
- ◯ Mental health / behavioral health records
- ◯ Medication and prescription history
- ◯ Laboratory and diagnostic test results
- ◯ Imaging and radiology reports
- ◯ Hospital, emergency room, or urgent care records
- ◯ Immunization records

Time Period of Records to Be Released (Please select one):

Since Beginning of Care: If (Yes) is selected, please skip the **Records from ___ to ___ section, as no date range is required.**

☐ YES

Records from _____ to _____

This authorization is effective from the date signed and will remain in effect for the duration of my care with Integrated Care LLC, unless an earlier expiration date is specified below. Expiration date (if applicable): _____

By initialing below, I specifically authorize the release of sensitive information where applicable, including mental health, substance use, HIV/AIDS, and other protected health information as allowed by federal and state law.

Please sign your name below *

Signature

Date

☐ I am the parent/guardian of this patient