Maui Memory Clinic
2145 Wells St. Suite 202
Wailuku, Hi 96793
PH: (808) 244-1007
Fax (808) 442-0041
Dr.Tom@MauiMemoryClinic.com

Patient Information

Patient Name: ___________________________ **Date of Birth:** __________________

Maiden/Other legal name: ______________________________

Last 4 of SSN#: XXX-XX-____________________ **Phone:** ______________________

Record Holder: Maui Memory Clinic 2145 Wells St. Ste. 202 Wailuku Hi 96793

Phone: (808) 244-1007 **Fax:** (808) 244-0041

Release Records to: **All Electronic copies are a flat fee of $5.00**

Name of Clinic/ Provider/ Person Records to: ____

Street Address/ City / State / Zip/encrypted e-mail: _____________________________________

Phone: ____________________________ **Fax:** ____________________________

Purpose: (Please Circle One)

Continued Care Legal Personal Insurance Disability

Other (please specify): Coordination of Care ____

Health Information to be released: (What do you want to be Released?)

Routine Record Sets: - For dates of service: ____

☐ **Clinic visit** (office notes, procedure notes, operative notes, lab, diagnostic and radiology reports)

☐ **Other Records - Please Specify Type:** Neuropsychological Evaluation Report_____________

☐ **Billing Records**

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Authorization:

The Health Insurance Portability and Accountability Act (HIPAA) and its regulations (45 CFR 164.508) prohibit us and other healthcare providers, health insurers and medical centers from releasing your health information without consent. If you authorize us to release some or all of your healthcare information to a person or organization not covered by HIPAA, it is highly possible that the healthcare information we release will no longer be private or protected or confidential and may be distributed to others. Examples of persons and organizations not covered by HIPAA are lawyers and insurance companies (e.g., auto or life insurance). You may refuse to sign this authorization and it will not affect the treatment you receive from MMC and its providers in any way – we will still offer you the same level of care, courtesy, and professionalism. After you sign this request & authorization, you may revoke it at any time, but you must do so in writing to us. Our receipt of your signed revocation will not apply to information previously released but will cause us not to release further information. In accordance with the Hawaii Health Care Privacy Harmonization Act(HRS §323B), any medical records pertaining to HIV/AIDS related , genetic testing, mental health, and/or drug and alcohol treatment information is no longer subject to special state privacy rules and may be included in the information released pursuant to this request & authorization, except as to information protected under 42 CFR Part2, which may not be disclosed or redisclosed without my authorization.

Signature of Patient or Authorized Representative: ___________________________________

Print Name: ___________________________ **Date:** ______________ **Time:** ________ **AM/PM**

*If your relationship to the patient is not that of a parent to a minor Relationship (If signed by other than Patient) child, you must show documentation of your legal right. Ex POA or other document Unless otherwise revoked **this authorization will expire 12 months** after the date of signing this form.

*** Staff Use Info Released By: Maile Harding**/ Dr. Tom Harding **On Date:** _____________