MAMAKA O MĀLAMA

Ira D. Zunin, MD
Yefim Levy, MD
Julie Lacasa-Takishima, PhD
Psychologist

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I hereby authorize:

Provider/Facility Name: _____ ☐ A.S.A.P

Address: _____

Phone #: _____ Fax #: _____

To release the following information to Mamaka O Mālama:

☐ Ira Zunin, MD., M.P.H. ☐ Yefim Levy, MD ☐ Julie Lacasa-Takishima, PhD

☐ Julie Rizzolo, APRN ☐ Christopher S. Acree, PA-C

Information pertaining to the care and treatment of:

Patient Name: _____

Address: _____

Birth date: _____

Covering the period(s) of healthcare:

From (date) _____ to _____

Information to be disclosed:

☐ Complete medical records ☐ Laboratory tests ☐ Consultations reports

☐ Progress notes ☐ Radiology reports ☐ Other: _____

I understand this will include information relating to (initial if applicable):

_____ Acquired Immunodeficiency Syndrome (AIDS), Infection with Human Immunodeficiency Virus (HIV), or HIV testing

_____ Mental health records, psychotherapy or counseling, psychiatric care

_____ Treatment for alcohol and/or drug abuse

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: If not so specified, authorization will expire one year from date signed: _____

I recognize that the protected health information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I hereby release Mamaka O Mālama, the health care providers, attending physicians, and employees from any liability and all claims of any nature whatsoever pertaining to disclosure of information, or any professional opinions, findings or recommendations contained in the Zunin Center records.

Signed: _____ _____
Patient Date