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MANAKAI O MALAMA

Ira D. Zunin, M.D.
Preventive & Occupational Medicine
Integrative & Primary Care

[illegible] Takishima-Takishima, PsyD
Psychologist

Yefim Levy, MD
Internal Medicine & Primary Care

Christopher Acres, PA-C
Physician Assistant [illegible]

Maile Green, ND
Naturopath

Integrative Health Care Group & Rehabilitation Center

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

I hereby authorize Manakai O Malama to release to:

______________________________ ______________________

______________________________ ______________________

For the purpose of ______________________________ ______________________________ __________

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 ☐ X-ray reports ☐ Other(please specify)________________

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 this authorization may be revoked in writing at any time, except to the extent that action has been taking in reliance to this authorization. Unless otherwise revoked this authorization will expire on the following date, event or condition

I recognize that the protected health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I hereby release Manakai O Malama, the health center and it's attending physicians and employees from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or any professional opinions, findings or recommendations as contained in the Health Center records.

Please note: If you are transferring out of our clinic, we will happily provide one copy of your records directly to your new physician as a courtesy. Patients requesting records for personal use or transfer are required to pay reasonable copying fees before records will be released.

Signed: ______________________ ______________________

Patient Date