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

Yefim Levy, MD
Internal Medicine & Primary Care

Julie Lacasa-Takishima, PhD
Psychologist

Integrative Healthcare Group & Rehabilitation Center

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I hereby authorize:

Provider/Facility Name: ______________________________ ❑ **A.S.A.P**

Address: ______________________________

Phone #: ______________ **Fax #:** ______________

To release the following information to Manakai O Malama:

❑ **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 this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition. If no date listed, authorization will expire one year from date signed: ______________

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 '0 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.

Signed: ______________________________ ______________

Patient Date