RevitalizeMaui
CENTER FOR LONGEVITY MEDICINE & AESTHETICS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

You should use this form to submit to your Physician's office to release records to RevitalizeMaui.

Name of Facility or Person:_____

Address:_____

Telephone Number: ( ) _____ –_____ Fax Number: ( ) _____– _____

THE PURPOSE FOR THIS RELEASE:

You are hereby authorized to furnish and release to RevitalizeMaui all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

- Alcohol or Drug Abuse: ☐Yes ☐No
- Communicable disease related information, including AIDS or ARC diagnosis and/or HIV or HTLA-III test results or treatment: ☐Yes ☐No
- Genetic Testing: ☐Yes ☐No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease related information, the information is from confidential records which are protected by state or federal laws that prohibit further disclosure with the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not suficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release RevitalizeMaui, its employees, agents, managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand that there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continuing medical care.

Please Print Your Name_____ DOB_____

Patient Signature_____ Date_____

PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE OR PASSPORT ALONG WITH THE COMPLETED AND SIGNED FORM

Information Released: _____ Date:_____

Medical Records Technician Name: _____

Signature: _____

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