Dr Sarah B Strong, ND
PO Box 127 Hilo, HI 96721
Main Office Phone: 808.933.HEAL Fax: 1.808.969.9350

Authorization to Release Confidential Health Information

I Hereby Authorize:

❍ Dr Sarah Strong, ND

❍ Facility/Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____-_____

Phone#:_____ Fax #: _____

To Release:

❍ Complete Chart Record *(does not include billing information or radiographic images)*

❍ Chart Notes: ❍All ❍Specify: _____

❍ Labs/Reports: ❍All ❍Specify: _____

❍ Billing Records: ❍All ❍Specify: _____

❍ X-rays/Radiographic Images(specify): _____

❍Other:_____

From the Health Records of:

Name: _____ Date of Birth: _____/_____/_____

Soc. Sec. Number: _____ Daytime Phone: _____ ext:: _____

Are you authorizing release of your own records? ❍Yes ❍No

Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

To be Released to:

❍ Dr Sarah Strong, ND ❍ **Self** (please provide address below if requesting a copy of your own records)

❍ Facility/Doctor: _____

Address: _____

City: _____ State: _____ Zip: _____-_____

Phone #: _____ Fax #: _____

For the Purpose of:

❍Adjunctive/Concurrent Care ❍Transfer of Care ❍ Other: _____

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document..

Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to:

(check the accompanying box(s) below to EXCLUDE the information from authorization)

❍ substance abuse ❍ mental health/psychotherapy notes ❍ sexually transmitted diseases and ❍ HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call Dr Strong to inquire about revoking this authorization.

_____ _____

Guardian/Personal Representative's Name (PRINT) Patient's Name (PRINT)

_____ _____

Guardian/Personal Representative's Signature Patient's Signature

_____ _____

Relationship/Representative's Authority Date