KAISER PERMANENTE. HAWAII REGION

Authorization for Release of **Protected Health Information**

ME: #: Name: Sex/BD:

I hor	eby authorize: ()	Date Format: MM / DD / YYYY	
	Total		
Addre			7.004
	City:	State:	Zip Code:
Relea	ase to: ()		
		tothro	
	Patient <u>or</u> Authorized Represent Kalser Permanente Medical Cen	iter: 3288 Moanalua Road, Hon	olulu Hawaii 96819 [,]
	Attention Outpatient Medical F	Records for: Physician • Department	• Location
C. LIF			
		Ot-1	
			Zip Code:
	Attention:		Dept:
Pertain	ing to the care of:		
Name	: Last	First	M.I
			Birthdate:
rui lile	purpose or.		
Disclo	ifection, AIDs, or ARC, drug and a	information about medical history, railcohol use, and other personal in	nformation unless otherwise specifi
Disclo HIV in	sure is authorized for any and all i ifection, AIDs, or ARC, drug and a	alcohol use, and other personal in	nformation unless otherwise specifi
Disclo HIV in	sure is authorized for any and all i ifection, AIDs, or ARC, drug and a	alcohol use, and other personal in	mental and physical condition, includinformation unless otherwise specificate of those charges will be provide
Pees: A reaupon Duratio	ssure is authorized for any and all infection, AIDs, or ARC, drug and a second	duplication of records. An estim	nformation unless otherwise specificate of those charges will be provide
Fees: A reaupon Duration This a prior pepa	sure is authorized for any and all infection, AIDs, or ARC, drug and a sonable fee will be charged for a request prior to duplication. On of validity: Buthorization is valid for six (6) mosts (6) months. The undersigned	duplication of records. An estiments from the date of signing unless d may revoke this by submitting a conclute. Hawaii 96819. I understate	nformation unless otherwise specifi
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