Foley Ob and Aesthetics
Stephen Foley, MD

Request & Authorization for Release of Your Private Protected Health Information

Please carefully read & understand the following information before you complete & sign this release. Your signature at the bottom of this page is undeniable proof that you have done so. The Health Insurance Portability and Accountability Act (HIPAA) and its regulations (45 CFR 164.508) prohibit us and other healthcare providers, health insurers and medical centers from releasing your health information without your consent. If you authorize us to release some or all of your healthcare information to a person or organization not covered by HIPAA, it is highly possible that the healthcare information we release will no longer be private or protected or confidential and may be distributed to others. Examples of persons and organizations not covered by HIPAA are lawyers and insurance companies (e.g., auto or life insurance). You may refuse to sign this authorization and it will not affect the treatment you receive from Foley Ob and Aesthetics and its providers in any way – we will still offer you the same level of care, courtesy, and professionalism, After you sign this request & authorization, you may revoke it at any time, but you must do so in writing to us. Our receipt of your signed revocation will not apply to information previously released but will cause us not to release further information. In accordance with the Hawaii Health Care Privacy Harmonization Act(HRS §323B), any medical records pertaining to HIV/AIDS related information, genetic testing information, mental health information, and/or drug and alcohol treatment information is no longer subject to special state privacy rules and may be included in the information released pursuant to this request & authorization, except as to information protected under 42 CFR Part2, which may not be disclosed or undisclosed without my authorization.

Legal Name of Patient: Former Legal Name: Date of Birth:

Name(s) of persons or party to release my information:

- ☐ Foley Ob and Aesthetics

Provider/Health Organization: Phone: Fax:

Address of Provider

Dates of service: _____ from _____

- ☐ Progress Notes
- ☐ Lab Reports
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Billing Summary
- ☐ Other: _____

Name(s) of persons or party to receive my information:

- ☐ Foley Ob and Aesthetics

Provider/Health Organization: Phone: Fax:

Foley Ob and Aesthetics
Stephen Foley, MD

Address of Provider

The purpose of this disclosure is:

- ☐ At my request
- ☐ Change of Insurance or Physician
- ☐ Continuity of Care
- ☐ Other:

This authorization to use or disclose your health information will expire according to the following. You can specify below (Please check one), or if an expiration date or event is not specified, this authorization will expire one year from the date of signature.

- ☐ On this date (indicate when you want this authorization to expire):
- ☐ Upon this specific event (describe event):
- ☐ When I revoke this authorization to Foley Ob and Aesthetics in writing

There is a $0.50 per page fee for records and a separate fee for certified mail receipt postage.
NO Cost for requests directly sent to a healthcare provider. Minimum of 30 business day processing time on requests.

I have read and understand this information provided to me. I am the patient or I am authorized to act on behalf of the patient to sign this document authorizing the use or disclosure of Protected Health Information under the above terms.

Legal Name of Patient: Signature: Date Signed:

Relationship (If signed by other than patient): _____

***If your relationship to the patient is not that of a parent to a minor child, you must show documentation of your legal right to make this request (e.g. power of attorney, court-appointed guardianship, surrogate, etc.)**

If the Name(s) of persons or parties to release the above patient's information to Foley Ob and Aesthetics, please fax this request to 805-856-1568 or by email at office@foleyobandaesthetics.com.

If you have any questions related to this form, or your medical record request, or for follow-up information regarding your request, please contact Foley Ob and Aesthetics at 808-762-0261.

For Foley Ob and Aesthetics Use Only:

Date Received: Notes: