Medical Records Request

To request a copy of your records, please fill out the Authorization for Use and Disclosure of Medical Information form. You can either mail the form back to us or you can fax the form to 808-373-3666.

Orthosport Hawaii
5722 Kalanianaole Hwy., Lower Level
Honolulu, HI 96821

Once your request is processed and fulfilled we will either mail your copy to the address specified on the authorization form, or you may make arrangements to pick up your copies from our offices located at the address above during our business hours:

8:00 a.m. to 6:30 p.m., Monday through Friday 8:00 a.m. to 12:30 p.m., Saturday

The copying charges for your medical records will be $30 for first 50 pages & .25¢ for each additional page. Fees include postage via USPS Priority Mail. We will contact you to let you know how much the total charge will be once we retrieve your records. You may pay by debit/credit card (VISA, MC, DISCOVER) or send a check by mail (to the address above). Payment must be received before we can copy your records.

Should you wish to contact us with any questions, you may call 808-373-3555.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Please complete, sign and return this form to: *or* submit via fax to 808-373-3666. Contact us at 808-373-3555 with questions.
OrthoSport Hawaii
5722 Kalanianaole Hwy., Lower Level
Honolulu, HI 96821

I authorize _____ to release the protected health information of the following:

_____ _____
Patient Name Birthdate

To: _____
Name of Recipient

_____
Address City State Zip Code

_____ _____
Phone Fax

Information to be disclosed:	*Purpose for Use and/or Disclosure
Date(s) of Service:_____	☐ At the request of the individual
☐ Medical Records ☐ X-Ray/Imaging Reports	☐ Legal purposes
☐ Treatment Records ☐ Entire Record	☐ Insurance
☐ Diagnostic Records	☐ Physician Follow-Up
☐ Other:	☐ Other _____
Please Specify:_____	

____(initial) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, alcohol and/or drug abuse treatment, or behavioral or mental health services. (Unless I specifically agree, the information will not be disclosed).

Unless otherwise revoked, this authorization will expire on the following date or event: _____.
If date or event is not specified, this authorization will expire one year from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and the above-named health provider will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed by law.

I understand that I may revoke this authorization at any time by notifying the above-named health care provider, in writing, of my revocation. I understand that the revocation will not apply to any information that is already released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under the federal privacy regulations.

I release the above-named health care provider from all liability and claims whatsoever pertaining to the disclosure of information as continued in the records released pursuant to this authorization.

A copy of this release shall have the full force and effect of the executed original.

Requestor: _____ _____
Signature Print Name

_____
Date

Relationship: _____
(Relationship to Patient) Complete only if requestor is not patient

*****Please make a copy of this release for your records*****