**VALLY MEDICAL GROUP, APC**
82 Puuhonu Pl Ste 202-203 Hilo, HI 96720
P: 808 935 6353
F: 888 511 6031
vallymedicalgroup@gmail.com

# Release of Information

Last Name: _____First Name:_____
Former Name:_____
Date of Birth: _____
Mailing Address:_____
Home Phone:_____Cell Phone:_____
I authorize release of my health information to include complete chart records, all radiology and pathology reports and lab reports to/from:
Name:_____
Address:_____
Phone:_____Fax:_____
Email:_____
To be released to/from:

Vally Medical Group
82 Pu'uhonu Place #202-203
Hilo, HI 96720
Phone: (808)935-6353 Fax:(888)511-6031
Email: vallymedicalgroup@gmail.com

-I understand and acknowledge that my medical records may include information regarding treatment for physical illness, alcohol/drug abuse and or HIV/AIDS test results or diagnosis.

-I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no lobnger be protected by Federal and State law. However, I understand the information related to alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or redisclosed without my authorization.

-I understand thatmy healthcare information is protected by state and federal regulations that protect the confidentialityof this information and that my hgealthcare information may not be released/disclosed without my written authorization, unless otherwise provided for by the law.

Patient Signature:_____ Date:_____