Mango Medical

Authorization for Release of Medical Information: ☐ Patient Request ☐ Switching Primary Care

Patient Name: _____
Mailing Address: _____
Phone:_____ SSN:_____ DOB:_____

I Authorize Release of of My Medical Record: ☐ To ☐ From
Doctor, Phone & Fax _____
Doctor, Phone & Fax _____
Other, Phone & Fax _____

Please Send My Medical Record: ☐ To ☐ From
☐ *Mango Medical Waimea* --- 64-1032 Mamalahoa Hwy Suite 306 Kamuela, HI 96743
Email: Waimea@mangomed.org Fax: 808.769.5208 Phone: 808.769.5010
☐ *Mango Medical Kona* --- 75-5591 Palani Road Suite 3002 Kailua-Kona, HI 96740
Email: Kona@mangomed.org Fax: 808.443.2621 Phone: 808.769.5167
☐ *Mango Medical Hilo* --- 21C Kalanianaole Ave Hilo, HI 96720
Email: Hilo@mangomed.org Fax: 808.930.1033 Phone: 808.930.1010
☐ *Mango Medical Ocean View* --- P.O. Box 6065 Ocean View, HI 96737
Email: OceanView@mangomed.org Fax: 808.939.8102 Phone: 808.939.8100
☐ *Mango Medical Wailuku* --- 1935 Main Street Suite 102 Wailuku, HI 96793
Email: Wailuku@mangomed.org Fax: 808.442.3250 Phone: 808.442.3245
☐ *Mango Medical Makawao* --- 1120A Makawao Ave Makawao, HI 96768
Email: Pueo@mangomed.org Fax: 808.586.2727 Phone: 808.573.2222

Type of Information to be Released: ☐ Full Medical Record ☐ Specified Information Only
☐ Medications & Therapies_____
☐ Accidents & Injuries_____
☐ Operative Reports_____
☐ History & Physical_____
☐ Labs & Imaging_____
☐ Immunizations_____
☐ Other_____

Release of Protected or Sensitive Information: Please Initial the Applicable Items Below
_____Drug Abuse Diagnosis/Treatment _____Alcoholism Diagnosis/Treatment _____Genetic Tests
_____HIV/AIDS Records _____Sexually Transmitted Disease _____Mental Health Treatment

I understand that my records may be subject to redisclosure by the recipient(s) & is unprotected by state & federal law. This authorization remains effective until revoked or until I am no longer a patient of Mango Medical. I understand that I may revoke this authorization at anytime by providing a written notification, except to the extent that action has been taken in reliance of this authorization; or if this authorization was a condition of obtaining insurance, other law provides the insurer with the right to context under the policy. I understand that I may inspect or copy the information that is used or disclosed.

_____ _____ _____
Signature of Patient or Legally Responsible Person Relationship to Patient Date

In order to provide the highest quality of care, we request new patients to have all their prior records on file prior to your first visit. It is the preference of Mango Medical to receive patient medical records via fax directly into our secured EMR system. It is the policy of this office not to email patient records; if requested for release we will fax to the number specified above or mail out a disc.