Hawaii Center for Regenerative Medicine, LLC
Liza Maniquis-Smigel, MD
PM&R, Spine, Sports, & Electrodiagnostic Medicine
Prolotherapy, Platelet Rich Plasma, Stem Cell
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I,_____hereby request and authorize

Liza Maniquis-Smigel, M.D.
_____To Obtain From
_____To Release To

_____
Name of Physician, Medical Group, Agency or Person

_____
Address City, State, Zip

_____ _____
Phone Fax

The following protected health information:

_____Complete Medical Records
_____Laboratory Reports
_____Operative Reports
_____Other (describe): _____
_____Radiology Reports
_____History and Physical Exam Reports
_____Consultation Reports

For the purpose of: _____

Regarding Patient:

Name: _____,_____ ___ _____
Last First MI Date of Birth

Records may include the following *only if initialed by patient:*
_____Information relating to diagnosis/treatment of HIV
_____Information relating to diagnosis/treatment of alcohol, illegal/prescription drug abuse
_____Information relating to psychiatric diagnosis/treatment

_____I understand that by not authorizing release of the above information, I may leave my physician without important medical information that may adversely affect my health, including the possibility of death.
_____I understand that the release of psychiatric information DOES NOT INCLUDE psychotherapy notes from my psychologist or psychiatrist.

This authorization shall be valid for 6 months from date of signature and I have the right to revoke the authorization at any time with notification in writing. Revocation will not pertain to records released prior to notification.

_____ _____
Patient's Signature **Date**