Akamai

Nathalie E. Sowers, DPM

Podiatric Medicine and Surgery
Main Office: 932 Ward Avenue, Suite #400 Honolulu, HI 96814
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Phone: (808) 942-3644 Fax: (808) 955-7970

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I authorize AKAMAI FOOT DOCTOR, LLC to release the protected health information of:

*__Patient Name:__ _____

__Date of Birth__: ____/_____/_____ __Phone__: _____-_____-_____

TO: NATHALIE E. SOWERS, DPM
AKAMAI FOOT DOCTOR, LLC
932 WARD AVENUE, SUIRE
400 HONOLULU, HI 96818
PHONE: (808) 942-3644
FAX: (808) 955-7970

*Items that **MUST** be completed for authorization to be valid

*Information to be disclosed:	*Purposes for Use and/or Disclosure (check as many as apply):
☐ All medical records ☐ Lab/Imaging Reports	☐ At the request of the individual
☐ Clinical notes ☐ X-ray Film(s)	☐ Legal Purposes
☐ HIV test results **specify** ( ) Yes ( ) No	☐ Insurance
☐ Restrict to the following dates/ conditions: _____	☐ Physician follow-up
☐ Restrict to information necessary to complete form provided	☐ Other: _____
☐Other (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. (If I do not specifically agree, this information will not be disclosed.)

***Unless otherwise revoked, this authorization will expire on the following date or event: _____.**

If a 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 that my refusal to sign will not affect my ability to obtain treatment from Akamai Foot Doctor, LLC, nor will it affect my eligibility for benefits.

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (e.g., a letter) addressed to
Akamai Foot Doctor, LLC. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon 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 federal privacy regulations.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with
the requirements of the federal privacy protection regulations.

I hereby release Akamai Foot Doctor, LLC from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Akamai Foot
Doctor, LLC. I certify that I have received a signed copy of this authorization.

I understand that I will be assessed a flat fee of $50 for this service and $1.00 for each page thereafter, including toner copies of x-rays.

If delivery is requested, I understand that I am also responsible for shipping costs at a minimum of $5.00 for first class mail. Doctor-to-doctor requests are processed without charge if shipping charges do not apply. Please allow 30 days to process request,
beyond delivery time.

Requestor_____ _____

***Signature** ***Print Name**

Relationship to Patient_____ _____/_____/_____

***(Complete if Requestor is NOT the patient)** ***Date**

Revised 6/12/2018
Form: AFD_MRF