BRIDGE MEDICINE, LLC

"We must be the change we wish to see in the world." -Ghandi

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: _________________________

I HEREBY AUTHORIZE:

Name: ____

Address: ____

____
City State Zip Code

_______________________ _________________
Phone Number Fax Number

TO RELEASE INFORMATION FROM MY MEDICAL RECORD TO:

Name: Mia Carson, MD

Address: 1120A Makawao Ave.
Makawao, HI. 96768

Phone: 808-573-7555
Fax: 808-573-7666

INFORMATION TO BE RELEASED:

☐ History and Medical Exam ☐ X-Ray Reports
☐ Progress Notes ` ☐ Lab Reports
☐ Other ____

PURPOSE OF DISCLOSURE:

☐ Diagnosis and treatment ☐ Continuing Care
☐ Insurance ☐ Consultation/Second Opinion
☐ Other ____

- I understand that this authorization will expire two years after the date of my last visit.
- I understand that I may revoke this authorization at any time.
- I have been advised of my right to receive a copy of this form.

Signature: ____ Today's Date: ___________________

Name relationship of person if not patient: ____

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Telephone: 808-573-7555 **Fax: 808-573-7666** **Email: admin@bridgemedicine.com**