

## **BEHAVIORAL HEALTH SERVICES**

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## AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH RECORDS

PATI	ENT	INFORMATION	I

Patient Name		Date of Birth			
Address		Phone Number			
	WAHIAWA HEALTH BEHAV DRDS TO/FROM:	IORAL HEALTH SP	ERVICES TO RELEASE A	ND/OR OBTAIN MY MENTAI	
Organization/Prov	ider				
Address:					
Phone	Email		Fax		
Pleas	Email Email	ords are authorized to b	e released and/or obtained wi	th an "X" mark below:	
PURPOSE OF R		INFORMATION TO BE RELEASED AND/OR OBTAINED			
□Legal Reasons	□ Referral for Treatment	□ Diagnosis	□ Lab/Pathology Reports	□ External Medical Records	
$\Box$ Copies for	$\Box$ Verification of Compliance	$\square$ Prognosis	$\Box$ Recommendations	□ Verification of Services	
Personal Use	$\Box$ Care Coordination	$\square$ Medications	□ Dates of Service	Emergency Information	
□Insurance	□ Disability Bus Pass	Progress Notes	□ Treatment Summary	□ Other:	
□Transfer Care	□ Other:	List time frame:	$\Box$ Treatment Plan		
□Treatment			□ Discharge Summary		
Planning			ç ,		
MY KIGHIS/M	IY AUTHORIZATION				
<ol> <li>taken in reliand</li> <li>I understand the purpose of disconstant of of disconstan</li></ol>	ce upon it. hat if I refuse to sign this authorization closure to others. formation used or disclosed under this we all liability from Wahiawā Health, by Wahiawā Health. hat my Behavioral Health records no rmation to the named recipient: hol and/or drug dependency treatment	on, I may not be eligible as authorization maybe di whatsoever pertaining to nay include sensitive inf records	for or receive research-related sclosed by the recipient and may the release of the protected heal formation. My <b>initials</b> below	extent that any action has already been treatment that I have requested for the y no longer be protected by federal and th information contained in the records indicate my permission to release the Mental health records	
7. Please initial 1	means by which information is author	ized to be transmitted:	FaxVerbal	Written	
By sig	gning below, I acknowledge that I l		initial initial	rights associated with it.	
SIGNATURE				5	
Printed Name of Pat	tient or Legally Responsible Party				
Signature of Patient					
-	ent, if not signed by Patient				
-					
FOR STAFF USI	ignature of WCCH Staff				
	essed by		Title	Date	
NOTICE ON RE	DISCLOSURE				

This information has been disclosed to and/or for you from health records that are protected by federal confidentiality rules (HIPAA and 42 CFR Part 2). These rules prohibit you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by HIPAA and 42 CFR Part 2. This authorization is NOT sufficient for this purpose. Federal rules also restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.