Wahiawā Center for Community Health
I ka lā i ka Mauliola...the sun at the source of life within
302 California Ave., Suite 106, Wahiawa HI, 96786 | www.wahiawahealth.org | phone: 808-622-1618 | fax: 877-759-6943

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I authorize, _____ to release protected health information of:
Facility Name

Facility Address: _____

Phone Number: _____ Fax Number: _____

PATIENT'S NAME (print): _____ Date of Birth: _____

Address: _____

City, State. Zip Code _____ Phone#: _____

RELEASE TO:

Facility/Provider/Organization Name: _____

Address: _____

Phone Number: _____ Fax: _____

TYPE OF INFORMATION TO DISCLOSE:

Date of Service: _____

☐ ALL medical records ☐ Imaging reports
☐ Consultation reports ☐ Laboratory results
☐ Other: _____

_____ (Initial) I agree to the release of the following information if it is in my records: ☐ Acquired Immune Deficiency Syndrome (AIDS) or ☐ Alcohol and/or drug abuse treatment or ☐ Behavioral or mental health services, or ☐ genetic information. Please mark box. If I do not agree, this information will not be disclosed.

PURPOSE OF DISCLOSURE:

☐ Patient Request
☐ Referral for treatment
☐ Legal request
☐ Worker's Comp
☐ Abuse/Neglect reporting
☐ Funeral home/Medical Examiner
☐ Transfer of care
☐ Required by law
☐ Research
☐ Organ donor
☐ Subpoena/ Court order
☐ Organ Donor

This request will expire on (date) _____. If date is not specified it will expire **one year** from date of signature below. I understand that I have the right to revoke this authorization by notifying in writing Wahiawa Health. This does not apply to any information already released in reliance on this authorization.

- I understand that if I refuse to sign this authorization, I may not be eligible for or receive research related treatment that I have requested for the purpose of disclosure to others.
- I understand that information used or disclosed under this authorization maybe disclosed by the recipient and may no longer be protected by federal and state law.
- I hereby release all liability from Wahiawa Health, whatsoever pertaining to the release of the protected health information contained in the records release to and by Wahiawa Health.

Requested by (print name): _____ **Signature**: _____

Relationship: _____ **Date:** _____