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

RECORDS RELEASE FORM
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. [ ] Reproductive Health information (requires affidavit) Please mark box. If I do not agree, this information will not be disclosed.

PURPOSE OF DISCLOSURE:

[ ] Patient Request   [ ] Transfer of care

[ ] Referral for treatment   [ ] Required by law

[ ] Legal request   [ ] Research

[ ] Worker's Comp   [ ] Organ donor

[ ] Abuse/Neglect reporting   [ ] Subpoena/ Court order

[ ] Funeral home/Medical Examiner [ ] 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:** _____