BEHAVIORAL HEALTH SERVICES
302 California Avenue, Suite 106 | Wahiawā, Hawai'i 96786
Office: (808) 622-1618 | Fax: (877) 759-6943

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH RECORDS

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Phone Number _____

I AUTHORIZE WAHIAWA HEALTH BEHAVIORAL HEALTH SERVICES TO RELEASE AND/OR OBTAIN MY MENTAL HEALTH RECORDS TO/FROM:

Organization/Provider _____

Address: _____

Phone _____ Email _____ Fax _____

Please specify which mental health records are authorized to be released and/or obtained with an "X" mark below:

PURPOSE OF RELEASE

- ☐ Legal Reasons
- ☐ Copies for Personal Use
- ☐ Insurance
- ☐ Transfer Care
- ☐ Treatment Planning
- ☐ Referral for Treatment
- ☐ Verification of Compliance
- ☐ Care Coordination
- ☐ Disability Bus Pass
- ☐ Other: _____

INFORMATION TO BE RELEASED AND/OR OBTAINED

- ☐ Diagnosis
- ☐ Prognosis
- ☐ Medications
- ☐ Progress Notes

List time frame: _____

- ☐ Lab/Pathology Reports
- ☐ Recommendations
- ☐ Dates of Service
- ☐ Treatment Summary
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ External Medical Records
- ☐ Verification of Services
- ☐ Emergency Information
- ☐ Other: _____ _____

MY RIGHTS / MY AUTHORIZATION

1. I understand that, unless revoked, this authorization will expire as follows: _____. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Wahiawā Health's Behavioral Health Services in writing at the address indicated above. By doing so, this authorization will cease to be effective on the date specified except to the extent that any action has already been taken in reliance upon it.
3. 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.
4. I understand information used or disclosed under this authorization maybe disclosed by the recipient and may no longer be protected by federal and state law.
5. I hereby release all liability from Wahiawā Health, whatsoever pertaining to the release of the protected health information contained in the records released to and by Wahiawā Health.
6. I understand that my Behavioral Health records may include sensitive information. My **initials** below indicate my permission to release the following information to the named recipient:
   _____ Alcohol and/or drug dependency treatment records _____ Mental health records
7. Please initial means by which information is authorized to be transmitted: _____Fax _____Verbal _____Written
   initial initial initial

By signing below, I acknowledge that I have read and understand this authorization and my rights associated with it.

SIGNATURE

Printed Name of Patient or Legally Responsible Party _____

Signature of Patient or Legally Responsible Party _____ Date _____

Relationship to Patient, if not signed by Patient _____

Printed Name and Signature of WCCH Staff _____ Date _____

FOR STAFF USE ONLY

Authorization Processed by _____ Title _____ Date _____

NOTICE ON REDISCLOSURE

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.