



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: _____

<u>PATIENT'S NAME</u> (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:

PURPOSE OF DISCLOSURE:

Date of Service: _____ <input type="checkbox"/> ALL medical records <input type="checkbox"/> Imaging reports <input type="checkbox"/> Consultation reports <input type="checkbox"/> Laboratory results <input type="checkbox"/> Other: _____ _____ (Initial) I agree to the release of the following information if it is in my records: <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or <input type="checkbox"/> Alcohol and/or drug abuse treatment or <input type="checkbox"/> Behavioral or mental health services, or <input type="checkbox"/> genetic information. <input type="checkbox"/> Reproductive Health information (requires affidavit) Please mark box. If I do not agree, this information will not be disclosed.	<input type="checkbox"/> Patient Request <input type="checkbox"/> Transfer of care <input type="checkbox"/> Referral for treatment <input type="checkbox"/> Required by law <input type="checkbox"/> Legal request <input type="checkbox"/> Research <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Organ donor <input type="checkbox"/> Abuse/Neglect reporting <input type="checkbox"/> Subpoena/ Court order <input type="checkbox"/> Funeral home/Medical Examiner <input type="checkbox"/> Organ Donor
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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:** _____