WAIMĀNALO HEALTH CENTER

Authorization for Release of Health Information

***Fees may apply to certain requests – contact Medical Records for fee amount*

Patient Name: _____ **DOB:** _____

***I hereby authorize:** ☐ Waimānalo Health Center ☐ Other Provider (Please list below)

***Release to:** ☐ Waimānalo Health Center ☐ Self ☐ Other (Please list below)

_____
Name of Provider, Person, or Institution

_____ _____ _____ _____ _____
Address | City, State | Zip Code | Phone Number | Fax Number

***To disclose the following information on the above-Named Individual:**

☐ Office Visits ☐ Most Recent Physical Exam ☐ Dental X-ray
☐ EKG/Lab/X-ray Reports ☐ Immunizations ☐ Dental Notes
☐ Progress Notes ☐ Entire Medical Record ☐ Other (Specify): _____

Date(s) if known: _____ _____

***For the purpose of: (choose all that apply)**

☐ Personal ☐ Legal ☐ Transferring care ☐ Insurance ☐ School
☐ Coordinating Care ☐ Other (Specify): _____

***Medical record to be sent by:**

☐ Fax ☐ Mail
☐ Paper (Pick-Up) ☐ N/A

_____ (initials) I understand that this consent gives permission to release any or all information pertaining to alcohol/drug dependency treatment records and mental health conditions if documented in the health record.

Duration: Unless a different date is specified here _____ (date) This authorization shall remain in effect for one year from date of signature.

Revocation: I can revoke this authorization by submitting a letter to:

Waimānalo Health Center
ATTN: Medical Records
41-1295 Kalaniana`ole Highway
Waimanalo, HI 96795

A revocation will not affect information disclosed prior to receipt of the revocation letter.

I expressly and voluntarily authorize disclosure of the above health and personal information for the purposes stated above. I further understand that I am not giving permission for any disclosure other than described above. I understand disclosure of my health and personal information is strictly confidential. I understand there may be a fee associated with this request, however, there is no charge for medical records sent to facilities for ongoing care or follow-up treatment. I understand disclosure of my health record and personal information is strictly confidential.

☐ I decline the release of my medical record to Waimānalo Health Center

_____ _____ _____
**Signature of Patient or Legal Guardian* | **Print Name* | **Date*

If signed by someone other than the patient or parent of a minor child, please indicate relationship. Submit documents to show authority to request information on the patient.

*Relationship to Patient: _____ *Phone Number: _____
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Items that MUST be completed for authorization to be valid