WAIMĀNALO HEALTH CENTER

Authorization for Release of Behavioral 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, in compliance with the terms of the Hawaii Revised Statues, any or all information pertaining to alcohol, drug, or substance abuse, HIV infection, AIDS, or AIDS-related complex and/or mental health conditions if documented in the health record. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted with the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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

BEHAVIORAL HEALTH DEPARTMENT USE ONLY:

*Signature of Witness: _____ *Date Signed: _____

Items that MUST be completed for authorization to be valid