



"CARING FOR OHANA, CARING FOR YOU"



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ **Date of Birth:** _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ **Evening Phone:** _____

I hereby authorize the release of records/Verbal Exchange of Information

From:

Physician/Organization: _____ Dr. _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To:

Physician/Organization/PT: _____ Dr. _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released:

- History & Physical Exam Dates: _____ Lab Reports Dates: _____
- Progress Notes Dates: _____ X-Ray Reports Dates: _____
- Other (please specify): _____ Dates: _____

I specifically authorize the release of information relating to:

- Substance abuse (including alcohol/drug abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)

Purpose of Disclosure: Changing Physicians Legal School Other (specify): _____

This authorization is valid for one year after the dated signature. The authorization may be revoked at any time in writing and will be effective on the date notified except to the extent action taken has already been taken in reliance upon it.

Patient/Parent/Legal Guardian/Authorized Person Signature: _____ **Date:** _____

Relationship to Patient: _____ Witness: _____

For office use only