"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:

HAMAKUA HEALTH CENTER, INC.

Address: 45-549 Plumeria Street City: Honokaa State: HI Zip: 96727

Phone: (808) 775-7204 Fax: (808) 930-2742

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.

Print Name: _____ **Signature:** _____ **Date:** _____

Relationship to Patient: _____