HALEIWA FAMILY HEALTH CENTER

66-125 Kamehameha Hwy.
Haleiwa, HI 96712
(808) 637-5087

95-1249 Meheula Prkwy.,Suite B10
Mililani, HI 96789-1797
(808) 623-2435

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) Patient Name:_____ Date of Birth:_____
Address: _____ Telephone: _____
_____ Patient No: _____

I hereby authorize _____
_____
_____

to disclose the following information for the purpose of _____.

Period of healthcare:
From (date): _____ to (date): _____

2) **Information to be disclosed:**

_____ Complete health record(s) _____ Laboratory tests
_____ Progress notes _____ X-ray reports
_____ ___Consultation reports _____ Other (please specify)_____

I understand this will include information relating to (initial if applicable):

_____ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus or HIV testing.
_____ Mental health records, psychotherapy or counseling, psychiatric care.
_____ Treatment for alcohol and/or drug abuse.

3) **I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:**_____

4) **The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.**

5) **Processing and copying fees necessary to comply with this information shall be borne by the patient or his appropriate guardian or legal counsel. Copies of the medical information herein authorized shall not be surrendered to the person to whom disclosure is authorized until processing and copy fees are paid in full.**

Authorization is given to disclose or release the above information to:

_____ _____
Phone

_____ _____
Fax

Signed: _____ _____
Patient Date

_____ _____
or Legal Representative Relationship to Patient Date

Witness: _____

PHYSICIAN'S AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

_____ _____
Physician's Signature **Date**