Hawai'i Island Community Health Center

RELEASE OF INFORMATION

Patient Last Name: _____ First Name: _____ Middle Initial : _____

Date of Birth: _____ Former Last Name (if any): _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

I authorize the release of my health information:

☐ **To** ☐ **From** (please check one box)

Hawai'i Island Community Health Center
75-5751 Kuakini Highway, Suite 203
Kailua Kona, HI 96740
Phone: (808) 326-5629
Fax: (808) 329-9451

☐ **To** ☐ **From** (please check one box)

Name: _____
Address: _____
Phone: _____
Fax: _____
Email: _____

Information to be Released/Obtained:

- ☐ Office Notes (6 Months)
- ☐ Labs (6 Months)
- ☐ Radiology (All)
- ☐ Pathology (All)
- ☐ Mammogram
- ☐ Colonoscopy
- ☐ Immunizations
- ☐ Complete record for the last 2 most recent years

Other: _____

Date Range: _____

I specifically authorize the release of information relating to:

_____ INITIALS Mental health (including psychotherapy notes)

_____ INITIALS Substance/Alcohol use

_____ INITIALS HIV-/AIDS-related information

Purpose of Release:

☐ Physician Change ☐ Continuing Care ☐ Consultation ☐ Disability Determination ☐ Other: _____

- I understand and acknowledge that my medical records may include information regarding treatment for physical illness, alcohol/drug abuse and or HIV/AIDS test results or diagnosis.
- I understand that I can revoke this authorization in writing at any time except to the extent that the action has already been taken thereon. This authorization will expire six months from the date of authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by Federal or State law. However, I understand the information related to education (FERPA, 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or redisclosed without my authorization.

_____ Patient/Personal Representative Signature

_____ Date

_____ Personal Representative/Legal Guardian (print name)

_____ Relationship to Patient

FOR STAFF USE *Intake:* _____ *Date:* _____ *Records Prep:* _____ *Date:* _____

Records Released: _____ *Date:* _____ *ID Verified:* _____ *Date:* _____