



HOSPITAL USE  
MEDICAL REC. NO: \_\_\_\_\_

**Wahiawa General Hospital**  
**128 Lehua Street, Wahiawa, HI 96786**  
**Authorization to Disclose Medical Information**  
**WGH-HIPAA-1400 • Item No. 8094466**

I hereby authorize \_\_\_\_\_ and its employees to disclose  
medical information on \_\_\_\_\_ Birth Date: \_\_\_\_\_  
(Patient's Name)

to \_\_\_\_\_  
(Person/organization to receive information)

address: \_\_\_\_\_

DATE(S) OF SERVICE OR HOSPITALIZATION(S): \_\_\_\_\_

PURPOSE OR NEED FOR DISCLOSURE: \_\_\_\_\_

The type and amount of information to be used or disclosed is as follows:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> most recent history and physical | <input type="checkbox"/> operative reports | <input type="checkbox"/> progress notes  |
| <input type="checkbox"/> most recent discharge summary    | <input type="checkbox"/> pathology reports | <input type="checkbox"/> imaging reports |
| <input type="checkbox"/> consultation reports             |  |  |

Type of films: \_\_\_\_\_

Other: \_\_\_\_\_

To the release of **psychiatric conditions, alcohol/substance abuse, HIV or AIDS:**

\_\_\_\_\_ I Do Consent (please initial)                      \_\_\_\_\_ I Do **NOT** Consent (please initial)

I hereby release \_\_\_\_\_ and its employees from all liability and  
claims as a result of the disclosure of medical information.

**UNDERSTANDING AND AGREEMENTS OF REQUESTOR:**

1. This authorization is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, and enrollment or eligibility of benefits.
2. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:  
\_\_\_\_\_. If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not apply to information that has already been released in response to this authorization.
4. I understand that once the information described herein is disclosed, it may be subject to redisclosure by the recipient and it may no longer be protected by federal privacy rules.

Signed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient/Legal Representative

Relationship to patient (if not signed by patient) \_\_\_\_\_

I have attached legal documents needed to execute request.

Witnessed by: \_\_\_\_\_