HOSPITAL USE
MEDICAL REC. NO: _______________

Wahiawa General Hospital
128 Lehua Street, Wahiawa, HI 96786
Authorization to Disclose Medical Information

I hereby authorize Wahiawa General Hospital and its employees to disclose

medical information on ____ Birth Date: ______________
(Patient's Name)

to ____
(Person/organization to receive information)

e-mail 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:

- ☐ most recent history and physical
- ☐ most recent discharge summary
- ☐ consultation reports
- ☐ operative reports
- ☐ pathology reports
- ☐ progress notes
- ☐ imaging reports

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 Wahiawa General Hospital 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 emailing Wahiawa General Hospital, 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: ____