



**Wahiawa General Hospital  
Authorization to Disclose Medical Information**

I hereby authorize Wahiawa General Hospital and its representatives 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:

- |   |  |  |
|---|--|--|
| <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             |  |  |

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 representatives from all liability and claims as a result of the disclosure of medical information.

**UNDERSTANDING AND AGREEMENTS OF REQUESTOR:**

- 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.
- 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.
- I understand that I may revoke this authorization at any time by emailing [my.records.request@wahiawageneral.org](mailto:my.records.request@wahiawageneral.org) but if I do, it will not apply to information that has already been released in response to this authorization.
- 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: \_\_\_\_\_