HEALTH INFORMATION TECHNOLOGY DEPARTMENT
86-260 Farrington Highway ■ Waianae, Hawai'i 96792
Office: (808) 697-3410 ■ Fax: (808) 697-3681

AUTHORIZATION TO RELEASE PATIENT HEALTH RECORDS

PATIENT INFORMATION

PATIENT NAME ______________________ DATE OF BIRTH ______________

ADDRESS ______________________ CITY, STATE, ZIP ______________

PHONE NUMBER ______________________ EMAIL ______________

INFORMATION TO BE RELEASED

FROM:	TO:
ORGANIZATION/PROVIDER WCCHC	ORGANIZATION/PROVIDER ______________
ADDRESS: 86-260 Farrington Hwy	ADDRESS: ______________
CITY, STATE, ZIP: Waianae, HI 96792	CITY, STATE, ZIP: ______________
PHONE: 808-697-3410 FAX: 808-697-3681	PHONE: ______________ FAX: ______________
EMAIL: medicalrecords@wcchc.com	EMAIL: ______________

FORMAT OF RECORDS

☐ Paper ☐ Picked Up By: ______________

☐ Mail to the "*Release to Address*" ☐ Faxed to ______________ (Physician Name/Health Care Facility) ______________ (Fax Number) ______________ (Office Phone Number)

☐ Electronic

PURPOSE OF RELEASE

☐ Transferring Care ☐ Insurance
☐ Copies for Personal Use ☐ Legal
☐ Other (specify below)
____

INFORMATION TO BE RELEASED

☐ Medical Records: Date: From ______________ To ______________
☐ Billing Records ☐ History & Physical ☐ Radiology Reports O CD O FILM
☐ Progress Notes ☐ Lab/Pathology Reports ☐ Other (please specify)
☐ ER Records ☐ Immunizations ______________

MY RIGHTS / MY AUTHORIZATION

I understand that authorizing the disclosure of my protected health information is voluntary. I understand that I do not need to sign this form in order to assure treatment at or payment to Waianae Coast Comprehensive Health Center. I understand that unless expressly authorized by me below, I am **NOT** permitting WCCHC to release any "sensitive" protected health information in my medical record. Sensitive medical information includes records for (1) mental health treatment, (2) sexually transmitted diseases, (3) HIV/AIDS treatment, (4) genetic testing, and (5) records for alcohol and/or substance abuse treatment. In order for WCCHC to release this sensitive information, I must identify each type of sensitive protected health information that I **WANT** to be released to the above-named recipient and initial in the space provided below. If I do **NOT** check any of these items, the sensitive protected health information designated below **WILL NOT** be released to the named recipient. Fees may apply to certain types of medical record release requests.

☐ Alcohol and/or Drug Dependency Treatment Records ☐ Mental Health Records
☐ HIV/AIDS (test results, diagnosis, and/or treatment) Records ☐ Genetic Test Records __________ (Patient Initials)

I can cancel this authorization at any time by writing to the Health Information Technology Department, as described in Waianae Coast Comprehensive Health Center's Notice of Privacy Practices. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release and/or distribution by the recipient that may not be protected by confidentiality laws. This authorization will expire in one year from the date signed below unless otherwise revoked or unless another date is entered here: ______________.

I hereby release Waianae Coast Comprehensive Health Center from all liability and all claims of any nature whatsoever pertaining to the disclosure of my protected health information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Waianae Coast Comprehensive Health Center.

SIGNATURE

Printed Name of Patient or Legally Responsible Party ______________________

Signature of Patient or Legally Responsible Party ______________________ Date ______________

Relationship to Patient, if not signed by Patient ______________________

Printed Name and Signature of Witness ______________________ Date ______________

FOR STAFF USE ONLY

Authorization Processed by ______________ Title ______________ Date ______________

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