



CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____, hereby authorize Ko'olauloa Health Center
Name of Patient or Guardian

P.O. Box 395 Kahuku, HI 96731 (808) 293-9231 (808) 293-1511
Mailing Address *City, State* *Zip Code* *Phone Number* *Fax Number*

To release information from the record/file of: _____
Name of Individual *Date of Birth*

To/Recipient: _____
Name of Individual or Entity to which disclosure is being made

Mailing Address *City, State* *Zip Code* *Phone Number* *Fax Number*

I specifically authorize the release of the **following information:**

<u>INFORMATION TO BE RELEASED</u>	<u>DATES</u>	<u>INFORMATION TO BE RELEASED</u>	<u>DATES</u>
<input type="checkbox"/> Office Visits – Last Year	_____	<input type="checkbox"/> Immunizations	_____
<input type="checkbox"/> EKG/Lab/X-ray Reports	_____	<input type="checkbox"/> Dental X-Ray	_____
<input type="checkbox"/> Most Recent Physical Exam	_____	<input type="checkbox"/> Dental Notes	_____
<input type="checkbox"/> Progress Notes	_____	<input type="checkbox"/> Other: _____	_____

The information released will be used for the following **purpose(s)**:

- Insurance Legal Transferring Care Other: _____

_____ I understand that this consent gives permission to release, in compliance with the terms of the Hawaii Revised Statutes, any or all information pertaining to alcohol, drug, or substance abuse, HIV infection, AIDS, or AIDS-related complex and/or mental health conditions if documented in the health record. **This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.**

I expressly and voluntarily authorize disclosure of the above health and personal information for the purposes stated above. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization in writing at any time, except to the extent that action has taken place. I understand disclosure of my health and personal information is strictly confidential. I understand there may be a fee associated with this request, however, there is no charge for medical records sent to facilities for ongoing care or follow up treatment.

This authorization is effective for one (1) year from the date signed.

Signature of Patient or Guardian *Relationship to Patient* *Date*

Signature of Witness *Date*