

# Patient Release Form

Please complete form and give to your current clinic or doctor

Patient Name \_\_\_\_\_ Patient DOB \_\_\_\_\_

Patient Phone \_\_\_\_\_

I authorize \_\_\_\_\_ *name of current doctor/clinic*

\_\_\_\_\_ *address*

\_\_\_\_\_ *city/state/zip code*

\_\_\_\_\_ *phone*

Please release my protected health information to:

**KAHUKU MEDICAL CENTER**



Fax number: (808) 293-5584

Mailing address: 56-117 Pualalea Street, Kahuku, Hawai'i 96731-2052

\_\_\_\_\_ (Patient Initials) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services. (If I do not specifically agree, this information will not be disclosed.)

This authorization is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment at Kahuku Medical Center (KMC), nor will it affect my eligibility for benefits.

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing (e.g. a letter) addressed to KMC. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. This authorization will expire one year from the date it is signed.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I hereby release KMC from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by KMC. I certify that I have received a signed copy of this authorization.

Patient \_\_\_\_\_

*signature*

\_\_\_\_\_

*print name*

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_