KO'OLAULOA
HEALTH CENTER

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ , hereby authorize Ko'olauloa Health Center

P.O. Box 395 Kahuku HI. 96731 (808) 293-9231 - Phone, (833) 449-2587- Fax

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:

INFORMATION TO BE RELEASED	DATES	INFORMATION TO BE RELEASED	DATES
☐ Office Visits - Last Year	_____	☐ Immunizations	_____
☐ EKG/Lab/X-ray Reports	_____	☐ Dental X-Ray	_____
☐ Most Recent Physical Exam	_____	☐ Dental Notes	_____
☐ Progress Notes	_____	☐ Other	_____

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

☐ Insurance ☐ Legal ☐ Transferring Care ☐ Other: _____

_____
Initial

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