Pali Women's
HEALTH CENTER
642 Ulukahiki St. #305
Kailua, HI 96734
Phone: (808) 261-6644 Fax: (808) 261-6645

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name ______________________________ Date of Birth ____________________

Address: ______________________________ SS#: ____________________

City/State/Zip: ______________________________ Phone: ____________________

Please **obtain** my medical information **from**:

Name of Physician, hospital, or other: ______________________________

Address ______________________________

Phone # ______________________________ Fax # ______________________________

For the purpose of: ______________________________

Records Requested: ______________________________

Patients must initial for the following:

______ Psychiatric Records/Behavioral Health/Mental Health Records
______ AIDS/HIV related records
______ Drug and/or alcohol/Substance abuse records

Please **release/send** my medical information **to**:

Name of Physician, hospital, or other: ______________________________

Address ______________________________

Phone # ______________________________ Fax # ______________________________

For the purpose of: ______________________________

Records to be released: ______________________________

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.
Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Signature: ______________________________ **Date:** ____________________
If signed by other than patient, indicate relationship: ______________________________
Witness: ______________________________

*************** FOR OFFICE USE ONLY***********************

Date Received: ____________________ Date Records Sent: ____________________