640 Ulukahiki St
Kailua, Hawaii 96734
Phone (808) 263-5153
Fax (808) 263-5385
E-mail AHCSMedicalRecords@ah.org

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

*** Indicates a REQUIRED field.**

Completion of this document authorizes the disclosure and use of health information about you.
Failure to provide all information requested may invalidate this authorization.

*Patient Name: _____ Medical Record #: _____

*Address: _____ *Date of Birth: _____

*City/State/Zip: _____ *Telephone Number: _____

Please **OBTAIN** Information **FROM:**		Please **SEND** my medical information **TO:**	
*Name of Provider/Organization		*Name of Provider/Organization	
*Street Address		*Street Address	
*City/State/Zip		*City/State/Zip	
*Telephone Number	*Fax Number	*Telephone Number	*Fax Number

*** Check delivery option:** ❑ Paper Copy ❑ CD (if available) ❑ Fax to Healthcare Provider/Organization
❑ E-Mail (encrypted) _____

*** What records do you want? (Check appropriate boxes below):**

a. Date(s) of Service: _____/_____/_____ through _____/_____/_____

❑ Discharge Summary ❑ Emergency Room Records ❑ Operative/Procedure Reports ❑ Billing
❑ Test Results (X-Rays, Lab/Pathology Results) Specify: _____
❑ Other (Immunization Records, Medication Lists) Specify: _____

b. I specifically authorize release of the following information (check as appropriate):

❑ Mental health treatment information _____(initial) ❑ HIV test results _____(initial)
❑ Alcohol/drug treatment information _____(initial)

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

*** For the Purpose of:** ❑ Patient Request ❑ Other: _____

PATIENT INFORMATION

Adventist Health Castle
640 Ulukahiki Street
Kailua, Hawaii 96734
Ph: (808) 263-5500

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Authorization to Release Medical Info

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
HIM

AHCS-4538 Revision Date (04/2020)

Limitations, if any: _____

(Per CMIA-CA Medical Information Act - requires this authorization is to include both the specific uses and the limitations, if any, on the use of the medical information by the person(s) or entities authorized to receive the medical information.)

***Duration:** This authorization shall become valid upon signature and shall expire on _____

(Specify date, no longer than **one year** from date signed – required.)

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **Health Information Management, 640 Ulukahiki St., Kailua, HI 96734**
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

***Signature:** _____

(Patient/Parent/Conservator/Guardian) Date/Time

If signed by other than patient, indicate relationship: _____

For Behavioral Health Records ONLY _____

(Signature of MINOR patient, if applicable) Date/Time

Witness: _____ Date: _____ Time: _____

I authorize _____ to pick up my medical records.

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

❑ REQUEST COMPLETED - DATE: _____ PREPARED BY: _____

❑ IDENTITY OF INDIVIDUAL AND/OR LEGAL REPRESENTATIVE VERIFIED (STAFF INITIALS): _____

Notes: _____

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