# Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

**I hearby authorize _____ (Print Name of Provider or Medical Facility) to release information from my medical record as indicated below to:**

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

**INFORMATION TO BE RELEASED:**

| | **DATES:** |
|---|---|
| ☐ History and Physical Exam | _____ |
| ☐ Progress Notes | _____ |
| ☐ Lab Reports | _____ |
| ☐ X-Ray Reports | _____ |
| ☐ Other: | _____ |

I specifically authorize the release of information relating to:

**Please Initial:**

☐ Substance Abuse (including alcohol/drug abuse) _____
☐ Mental Health (including psychotherapy notes) _____
☐ HIV related information (AIDS related testing) _____

**X** _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

**PURPOSE OF DISCLOSURE:**
☐ Changing Physicians ☐ Consultation/Second Opinion ☐ Continuing Care
☐ Legal ☐ School ☐ Insurance ☐ Workers Compensation
☐ Other (please specify): _____

1. I understand that this authorization will expire on _____ (Print the date this form expires) after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by _____ (Print name of Provider) for the purpose of:
   _____
   _____
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I understand that the Bay Clinic, Inc. or any representatives _____ ☐ will/ ☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with State of Hawaii statute, I will pay a fee of $ _____ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY
DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $_____._____