M O L O K A I
COMMUNITY HEALTH CENTER

RELEASE OF HEALTH INFORMATION

Date: _________________

Name: ____

Date of Birth: ____

I/We authorize Molokai Community Health Center to release my medical records to:

Name of Facility Records Being Released To: ____

Address of Facility: ____

Contact Name: ____________________________ **Phone:** _____________________ **Fax:** ______________________

Date(s) of Service: ____

Purpose of Request:

______ **Physician Care Follow up**

______ **Insurance** ________ **Other:** ____________________________________

Information to be Released:

[ ]	**Full Record with Labs**	[ ]	**Imaging Records**
[ ]	**Operative Report**	[ ]	**Lab Results**
[ ]	**Consults**	[ ]	**Other:** _______________________________________
[ ]	**History & Physical**	[ ]	**Other:** _______________________________________
[ ]	**Emergency Room Records**	[ ]	**Other:** _______________________________________

________ (initial) 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 a drug abuse treatment, or behavioral or mental health services.
(If I do not specifically agree, this information will not be disclosed):

Unless otherwise revoked, this authorization will expire on the following date or event: ____
If a date or event is not specified, this authorization will expire one year from my date of signature below.

This authorization is voluntary, I understand that I can refuse to sign this authorization and Molokai Ohana Health Care (MOHC) will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: (i) research-related treatment' or (ii) health care provided solely for disclosure to a third party or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determination.

I understand that I many revoke this authorization at any time by notifying the MOHC Records Department, in writing, of my revocation. This is described in the MOHC Notice of Privacy Practices. I understand that the revocation will not apply to any information that already was released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I hereby release Molokai Ohana Health Care 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 Molokai Ohana Health Care.

Patient Signature: ____ **Date:** ______________________________