M O L O K A I
COMMUNITY HEALTH CENTER

**REQUEST FOR HEALTH INFORMATION**

**Date:** _________________

**Name of Facility Records Are Needed From:** ___________________________________________________________

**Address of Facility:** ________________________________________________________________________________

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

**I/We are requesting medical, behavioral health, and/or dental records on the following patient:**

**Name:** _____________________________________________________

**Date of Birth:** ________________________________________________

**Date(s) of Service:** ____________________________________________

**Purpose of Request:**

______ **Physician/Dental Care Follow up**

**Patient Appointment Date:** ___________________ **Time:** ______________

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

**Information Requesting:**

| | | | |
|---|---|---|---|
| [ ] | **Full Record with Labs** | [ ] | **Imaging Records** |
| [ ] | **Operative Report** | [ ] | **Lab Results** |
| [ ] | **Consults** | [ ] | **Dental Clinical Notes and/or Dental X-Rays** |
| [ ] | **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/Guardian Signature:** _______________________________________________________ **Date:** ______________________________

**Please mail records to PO Box 2040 Kaunakakai HI 96748 or fax records to (808)553-5194**

**Phone (808)553-5038**