MOLOKAI COMMUNITY HEALTH CENTER

REQUEST OF HEALTH INFORMATION

DATE: _____

NAME: _____ **BIRTH DATE:** _____

ADDRESS: _____

AUTHORIZATION: I authorize the provider listed below to disclose my health information with Molokai Community Health Center.

[ ] Fax Records:
Medical: (808)553-5194
Dental: (808)553-3591
BH: (808)553-5854

[ ] Mail Records:
PO Box 2040
Kaunakakai HI 96748

PROVIDER: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

INFORMATION REQUESTED:

[ ] Complete Records
[ ] Emergency Room Records
[ ] Imaging/Lab Reports
[ ] Other: _____

PURPOSE OF REQUEST:

[ ] Change of Physician
[ ] Other: _____

ACKNOWLEDGEMENT:

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

I understand I may revoke this authorization at any time by notifying the Molokai Community Health Center in writing. I understand that the revocation will not apply to any information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one year from my date of signature below.

I understand the authorization is voluntary. I can refuse to sign this authorization and Molokai Community Health Center 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: research-related treatment, health care provided solely for disclosure to a third party or health plan initial enrollment/eligibility determinations, underwriting or risk rating determination.

I hereby release Molokai Community Health Center 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 Community Health Center.

I have read the above and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
SIGNATURE OF PATIENT **DATE**

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN (Must present proof of guardianship.) **DATE**