

**TODAY'S DATE:** \_\_\_\_\_**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_**ADDRESS:** \_\_\_\_\_**AUTHORIZATION:** I authorize the Molokai Community Health Center to release my health information to the following recipient.**RECIPIENT:** \_\_\_\_\_**ADDRESS:** \_\_\_\_\_**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_**INFORMATION TO RELEASE:**

- |   |  |
|---|--|
| <input type="checkbox"/> Complete Records       | <input type="checkbox"/> Imaging Reports |
| <input type="checkbox"/> Emergency Room Records | <input type="checkbox"/> Lab Results     |
| <input type="checkbox"/> Consultation Notes     | <input type="checkbox"/> Other: _____    |

**PURPOSE OF RELEASE:**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Follow-Up           | <input type="checkbox"/> Referral     |
| <input type="checkbox"/> Change of Physician | <input type="checkbox"/> 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**