



HOSPITAL USE
MEDICAL REC. NO: _____

Wahiawa General Hospital
128 Lehua Street, Wahiawa, HI 96786
Authorization to Disclose Medical Information
WGH-HIPAA-1400 • Item No. 8094466

I hereby authorize _____ and its employees to disclose
medical information on _____ Birth Date: _____
(Patient's Name)

to _____
(Person/organization to receive information)

address: _____

DATE(S) OF SERVICE OR HOSPITALIZATION(S): _____

PURPOSE OR NEED FOR DISCLOSURE: _____

The type and amount of information to be used or disclosed is as follows:

- | | | |
|---|--|--|
| <input type="checkbox"/> most recent history and physical | <input type="checkbox"/> operative reports | <input type="checkbox"/> progress notes |
| <input type="checkbox"/> most recent discharge summary | <input type="checkbox"/> pathology reports | <input type="checkbox"/> imaging reports |
| <input type="checkbox"/> consultation reports | | |

Type of films: _____

Other: _____

To the release of **psychiatric conditions, alcohol/substance abuse, HIV or AIDS:**

_____ I Do Consent (please initial) _____ I Do **NOT** Consent (please initial)

I hereby release _____ and its employees from all liability and
claims as a result of the disclosure of medical information.

UNDERSTANDING AND AGREEMENTS OF REQUESTOR:

1. This authorization is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, and enrollment or eligibility of benefits.
2. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ . If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not apply to information that has already been released in response to this authorization.
4. I understand that once the information described herein is disclosed, it may be subject to redisclosure by the recipient and it may no longer be protected by federal privacy rules.

Signed by: _____ Date: _____
Patient/Legal Representative

Relationship to patient (if not signed by patient) _____

I have attached legal documents needed to execute request.

Witnessed by: _____