University of Hawai'i
University Health Services Mānoa
1710 East-West Road, Honolulu, Hawai'i 96822
Phone 808-956-8965 Specialty Clinic Phone 808-956-6221

FAX: ☐ MAIN 808-956-3583 ☐ CLINIC 808-956-5834

CONSENT FOR RELEASE OF MEDICAL INFORMATION OR RECORDS

Information pertaining to the care and treatment of:

Patient's Name ____ UH ID No. ____ Date of Birth ____ Phone number ____

Name of sending person, agency or institution releasing information	**Name of receiving person, agency or institution**
I hereby authorize:	**Release to:**
Name ____	Name ____
Address ____	Address ____
City ____ State ____ Zip Code ____	City ____ State ____ Zip Code ____
	Via: ☐Pick-up ☐Mail ☐Fax no:________________ ☐UH File drop

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DISCLOSURE:	**Disclosure is authorized for the following report(s)/information only:** ____ **Disclosure of the records/information may be used only for the following purpose:** ____
DURATION:	**A reasonable fee may be charged for duplication of records. This consent is valid for six (6) months and may be withdrawn at any time with written request of the patient or person authorized to act in his/her behalf.**
REVOCATION:	**You may change your mind and revoke this Consent for Release at any time, except to the extent that UHSM has already acted based on this Authorization. To revoke this Authorization, you must write to: UHSM, 1710 East West Road, Honolulu, HI 96822**
REDISCLOSURE:	**Notice is hereby given to the patient or legal representative signing this Authorization that University Health Services cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental health treatment.**

____ **DATE** ____ **SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE/RELATIONSHIP**