UNIVERSITY OF HAWAI'I
LEEWARD COMMUNITY COLLEGE
96-045 Ala Ike, Pearl City, HI 96782-3393
Phone: (808) 455-0515 Fax (808) 455-0267

CONSENT FOR RELEASE OF MEDICAL INFORMATION OR RECORDS

I hereby authorize:

____
Name of Person/Agency releasing information

____
Address

____
City / State / Zip Code

Release to:

____
Name of Person/Agency to receive information

____
Address

____
City / State / Zip Code

Information pertaining to the care and treatment of:

____
Patient's Name Date of Birth

______ Initial	This consent [ ] includes [ ] does not include the release of any or all records pertaining to alcohol and/or drug abuse treatment and/or psychiatric care and/or a condition related to a sexually transmitted disease including human immunodeficiency virus (HIV). I understand that such information maybe not be released without my specific consent.
______ Initial	Disclosure is authorized for the following report(s)/Information only: ___ Vaccines/TB Information ___ Other ______________________________

Disclosure of the records/information may be used only for the following purposes:

____________ ______________________________
Date Signature of Patient OR Authorized Representative

____
Agency Representative

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 This consent is valid for six (6) months and may be withdrawn at any time with written request of the patient or person authorized to act in his/her behalf.

Revised 4/18/18