Castle Medical Center
Adventist Health
Exceptional Medicine by Exceptional People

640 Ulukahiki Street
Kailua, Hawaii 96734-4498
www.castlemed.org

Department: _____
Phone #: _____ Fax#: _____

Authorization to Release Medical Information

*Patient Name: _____ *Date of Birth: _____
Address: _____ SSN#: _____
City/State/Zip: _____ Phone: _____

*Check One: ☐ Pick up ☐ Mail to above address
☐ Please **OBTAIN** Information **FROM**:
☐ Please **SEND** Information **TO**:

_____
Name of physician, hospital, or other

_____
Street Address

_____
City/State/Zip Fax Number

***FOR THE PURPOSE OF:**
☐ Patient Care ☐ Self
☐ Insurance Claim ☐ Other

***List specific dates of records to be released:**

***Duration:** This authorization shall begin immediately and remain in effect until:
(date) _____.

***PLEASE SPECIFY WHAT TYPE OF INFORMATION YOU WANT RELEASED:**

_____

_____

***Patients must initial for the following (if applicable):**

_____ Psychiatric records/behavioral health/mental health Records

_____ AIDS/HIV related records

_____ Drug and/or alcohol/substance abuse records

You may be charged for records. See HIM for details.

☐ Please provide me my reports on a CD/DVD (no charge)

☐ Please email me my records at _____@_____ (no charge)

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.
Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see page 2 of this form for certain exceptions). I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see page 2 of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization had taken action in reliance upon this authorization.

***Signature**: _____
(Patient/legal representative) Date Time
If signed by other than patient, indicate relationship: _____

Witness: _____
***Required Field**

Castle Medical Center Kailua, Hawaii
AUTHORIZATION TO RELEASE

Rev. 04/12

PATIENT ID

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**********For Office Use Only**********

Date/Time Received: _____ Date/Time Records Sent: _____

☐ Identity of individual and/or legal representative verified

Notes:

_____ _____
Medical Record Number Clerks Initials

**********Revocation of Authorization**********

In accord with provisions of the Notice of Privacy Practices, I hereby revoke the
☐ **Above Authorization**
☐ **Authorization releasing information to: _____**
☐ **Authorization dated: _____**

Signature: _____
(Patient/legal representative) Date Time

If signed by other than patient, indicate relationship: _____

Witness: _____

**********For Office Use Only**********

Date Revocation Received: _____

☐ Identity of individual and/or legal representative verified

_____ _____
Medical Record Number Clerks Initials

Exceptions: The exceptions noted in the Rights section on page 1 of this form include: authorization for research; authorization for health plan enrollment; and authorization solely for the purpose of creating protected health information for a third party.

Retain in Patient Record