alo·ha psych ASSOCIATES, INC.

AUTHORIZATION TO RELEASE AND/0R OBTAIN HEALTHCARE INFORMATION

Patient Information

****Leave form blank if not intending to release information**

_____
Patient Name

(_____)_____
Phone Number

_____ / _____ / _____
Date of Birth

Street Address
_____

City and Zip Code
_____-_____-_____
Social Security Number

Please Indicate How You Would Like Your Health Information Shared:

[ ] Release [ ] Obtain [ ]Exchange (Release & Obtain)

I do hereby consent to the exchange and/or disclosure of information contained in my medical record between:

Alo.ha Psych Associates, Inc. _____ ***and***

Name:_____ **Name:**_____

Street Address: _____ **Street Address:** _____

Phone & Fax Number:_____ **Phone & Fax Number:** _____

I specifically request that the following information:

[ ] Mental health and medical history, including diagnosis
[ ] Records of outpatient treatment
[ ] Records of hospitalization and inpatient treatment
[ ] All diagnostic, psychological assessments
[ ] Other_____

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 will not affect my ability to obtain treatment (except information for a third party). I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with policy. This disclosure of medical/psychiatric information complies with the terms of the Confidentiality of Medical Information Act of 1981, section 56, et. Seq, California Civil Code.

I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon authorization. If it is not earlier revoked, this consent shall terminate without express revocation one year from date shown below.

I understand that the medical records and information to be released and/or obtained may contain information pertaining to psychiatric, drug and/or alcohol related evaluation and/or treatment, and may also contain confidential HIV (AIDS) related information, including educational, psychological and laboratory test results.

_____ _____ _____
Signature of Patient | Relationship (if other than self) | Date

_____ _____
Signature of Minor (Ages 12-17) | Date

_____ _____
Signature of Witness | Date