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:	**FOR THE PURPOSE OF:**
☐ Please **OBTAIN** Information **FROM**: ☐ Please **SEND** Information **TO**:	☐ Patient Care ☐ Self ☐ Insurance Claim ☐ Other
______________________________________ Name of physician, hospital, or other	**List specific dates of records to be released:**
______________________________________ Street Address	
______________________________________ City/State/Zip Fax Number	**Duration:** This authorization shall begin immediately and remain in effect until: (date) _________________________.

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS:
____
____

Patients must initial for the following:

_____ 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.

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: ______________________________

Castle Medical Center Kailua, Hawaii
AUTHORIZATION TO RELEASE

Authorization to Release Medical Info FORM 4538

PATIENT ID

Castle Medical Center
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Witness: ________________________________

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

Date Received: _________________________ **Date 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 herby 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