AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

(PLEASE PRINT CLEARLY)

Patient Name (Last, First, M.I.)		**Date of Birth**
Address	**City**	**Zip Code**
Phone Number	**ID Number**	**Type:**

☐ **I Authorize** (Provider/Facility Name)

Phone Number	**Fax Number**		
Address	**City**	**State**	**Zip Code**

To release my mental health records to:
Wellness Partners Hawaii, Inc., 850 W Hind Dr., Ste 210 Honolulu, HI 96821 | P: 808-379-6656 | F: 844-456-1151

☐ **I authorize Wellness Partners Hawaii Inc. to release my mental health records to:** Name (Person/Organization)

Phone Number	**Fax Number**		
Address	**City**	**State**	**Zip Code**

Purpose of Disclosure

☐ Further Mental Health Care ☐ Insurance ☐ Legal/Attorney
☐ Personal Use (fees apply) ☐ Other (specify): _____

Method of Disclosure

☐ Fax ☐ Mail ☐ Verbal

Information to be requested/released (check or fill in all that apply):

☐ Psychiatric Intake ☐ Progress Notes ☐ Entire Record *(Checking this will <u>not</u> authorize the release of treatment information related to alcohol/drug abuse, HIV/AIDS, Sexually Transmitted Diseases, and Psychotherapy Notes. To authorize the release of such sensitive information, your request must be explicitly indicated in writing below.)*
☐ Explanation or Summary (fees apply) ☐ Medication List
☐ Attendance Dates

☐ Date(s) of Service: From: _____ To: _____

☐ Only information related to (specify):

I understand that I may revoke this authorization at any time by notifying Wellness Partners Hawaii Inc. ("WPH") in writing, except to the extent that action has already been taken in reliance on this authorization. This authorization shall expire on _____ (*specify expiration date/event*). If no expiration date/event is listed, this authorization will terminate twelve (12) months after it is signed. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under applicable laws. I understand WPH, Bradley Kuo, LLC, and any of its affiliates will not condition evaluation or treatment on whether I sign this authorization. I understand that federal and state laws permit providers to charge a reasonable, cost-based fee for the copying of medical records and I will be responsible for the payment of any fees that may apply to my records request.

Patient Signature _____ **Date** _____

Wellness Partners Hawaii Inc. Provider Approval _____ **Date** _____

Representative/Parent Signature _____

Relationship _____ **Date** _____