AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

(PLEASE PRINT CLEARLY)

Fill out patient information in full

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

Complete this section to **request records be sent to WPH**

❒ **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. 6700 Kalanianaole Hwy Suite 201 Honolulu, HI 96825 | TEL: 808-379-6656 | FAX: 808-379-3750			

Complete this section to **release records from WPH**

❒ **I authorize Wellness Partners Hawaii Inc. to release my mental health records to:** (Person/Organization Name)			
Phone Number	**Fax Number**		
Address	**City**	**State**	**Zip Code**

Check appropriate box(es)

Purpose of Disclosure:	**Information to be requested/released:**
☐ Further Mental Health Care ☐ Insurance ☐ Legal/Attorney ☐ Personal Use (fees apply) ☐ Other (specify): _____	☐ Psychiatric Intake ☐ Explanation or Summary (fees apply) ☐ Progress Notes ☐ Medication List ☐ Attendance Dates ☐ Entire Record (Checking this will not 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 here: _____)
Method of Disclosure:	**Date(s) of Service:**
☐ Fax ☐ Email ☐ Mail ☐ Verbal ☐ Secure Patient Portal	☐ From: _____ To: _____

This statement of consent can be revoked at any time before disclosure of the information, and expires on _____ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation. I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations. I understand Bradley Kuo, LLC and its affiliates will not condition evaluation or treatment on whether I sign this authorization. Fees: I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for the payment of such fees.

Patient Signature: Date:

Legal Guardian/Patient Representative Signature: Date:

Legal Guardian/Representative Name (please print):

Legal Guardian/Representative Relationship to Patient:

Wellness Partners Hawaii Inc. Provider Approval: Date: