

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

WELLNESS PARTNERS HAWAII INC. DBA WELLNESS PARTNERS MENTAL HEALTH (WPMH)



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	<input type="checkbox"/> 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. DBA Wellness Partners Mental Health 6700 Kalanianaʻole Hwy Suite 201 Honolulu, HI 96825 TEL: 808-379-6656 FAX: 808-379-3750			
Complete this section to release records from WPH	<input type="checkbox"/> 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:	
	<input type="checkbox"/> Further Mental Health Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal/Attorney <input type="checkbox"/> Personal Use (fees apply) <input type="checkbox"/> Other (specify): _____		<input type="checkbox"/> Psychiatric Intake <input type="checkbox"/> Explanation or Summary (fees apply) <input type="checkbox"/> Progress Notes <input type="checkbox"/> Medication List <input type="checkbox"/> Attendance Dates <input type="checkbox"/> 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:	
	<input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Verbal <input type="checkbox"/> Secure Patient Portal		<input type="checkbox"/> 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 re-disclosed 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: _____