UNIVERSITY OF HAWAI`I AT HILO
STUDENT MEDICAL SERVICES

200 W. Kawili Street • Hilo, HI 96720
Phone (808) 932-7369 • Fax (808) 932-7368

CONSENT FOR RELEASE OF MEDICAL INFORMATION OR RECORDS

I hereby authorize:

Name of sending person, agency, or institution releasing information

__UH Hilo Student Medical Services__________________
__200 West Kawili Street____________________________
__Hilo, HI 96720___________________________________

To release to:

Name of receiving person, agency or institution

____
____
____
Phone____________________Fax____________________

Information pertaining to the care and treatment of:

____

Patient's Name **Birthdate**

_________ Initial

This consent [ ] includes [ ] does not include the release of any or all records pertaining to alcohol and/or drug abuse treatment and/or psychiatric care and/or a condition related to a sexually transmitted disease including human immunodeficiency virus (HIV). I understand that such information may not be released without my specific consent

________ Initial

I hereby agree that UHH Student Medical Services may obtain records from the UHH Counseling Services including treatment dates, diagnoses, assessment/test results, treatment plan, & identified issues re: medication, information relevant to medical condition or illness.

.
________ Initial

Disclosure is authorized for the following report(s)/information only:

____

Disclosure of the records/information may be used only for the following purpose:

____

__________________ ____
DATE SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

____
AGENCY REPRESENTATIVE

This consent is valid for six (6) months and may be withdrawn at any time with
written request of the patient or person authorized to act in his/her behalf

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