KONA
COMMUNITY HOSPITAL
Care You Can Count On

Medical Oncology
79-1019 Haukapila Street • Kealakekua, HI 96750
808-322-6910 • 808-322-6918 (fax)

RELEASE OF INFORMATION

Patient:_____ Date of birth: _____

I authorize the Medical Oncology Clinic at Kona Community Hospital to:

☐ Release ☐ Obtain information

to/from _____ regarding my medical care:

☐ Radiology reports
☐ Pathology reports
☐ Medical records
☐ Laboratory results
☐ Operative notes/reports
☐ Other: _____

Certain types of information CANNOT be released without my specific consent and knowledge, as indicated below. Therefore, I have initialed before each type of records that I authorize you to release. Cross out information not to be disclosed.

____ Alcohol and/or drug abuse treatment records
____ Mental health treatment records
____ Sexually transmitted diseases including AIDS and HIV testing records

I also authorize consent to participation in the electronic exchange of information which will electronically submit and obtain my pharmacy and medical information where available.

This consent has been made freely and without coercion. I have been given the opportunity to have this consent explained to me and to ask questions pertaining to this release of my information. I understand that that those who receive this information will abide by HIPAA in maintaining confidential practices and not disclose this information further without my consent, unless permitted by federal or state law.

_____ _____
Signature of patient, parent or guardian Date

_____
Print name of person who signed