GALLER RIMM BEHAVIORAL HEALTH SERVICES, INC.

1043 Makawao Ave, #201 Makawao HI 96768 – (o) 808-572-4500 **(f) 808-442-1050**

Consent to release medical information

I Authorize _____, to release the protected health information of the following person:

Patient Name:_____

Date of Birth:_____ **Phone:_____**

Address:_____ City:_____ St & Zip:_____

TO: Galler Rimm Behavioral Health Services; 1043 Makawao Ave, #201 Makawao HI 96768

Information to be disclosed (please check box(s)	**Purpose of use and/or disclosure:**
☐ **Entire Medical Record**	☐ **Change of care**
☐ **Most recent visit (s)**	☐ **At request of patient**
☐ **Other**	☐ **Other**
Please Specify:	**Please Specify:**

____ (Initial) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, alcohol and/or drug abuse treatment, or behavioral or metal health service (Unless I specifically agree, the information will not be disclosed).

A reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication. This authorization is voluntary. I understand that the above named health care provider(s) or health plan(s) will not condition m treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed by law. I understand that I may revoke this authorization at any time by notifying the above named provider(s) and or health plan(s), in writing, of my revocation. I understand that the revocation will not apply to any other information that is already released or used in reliance on the authorization and there may be other legal restrictions on my ability to revoke the authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, then the law provides my insurer with the right to contest a claim under my policy or my policy itself. I understand that the health information released under the authorization may be re-disclosed by the recipient and may no longer be protected under the federal privacy regulations.

I release the above named health care provider(s) from all liability and claims whatsoever pertaining to the disclosure of information as contained in the records released pursuant to this authorization.

Requestors Name:_____
Patient/Legally Authorized representative

Requestors Signature:_____

Relationship to patient (if not self)_____

Date:_____

1043 Makawao Ave. Suite 201 Makawao, Hawaii 96768
Phone: (808) 572-4500 Fax: (808) 442-1050