CONSENT FOR INSPECTION, COPYING AND/OR RELEASE OF PROTECTED HEALTH INFORMATION

I hearby authorize _____to allow the
(Name of facilty/physician)

inspection, copying and/or release of protected health information regarding:

Patient name: _____
Date of Birth: _____SSN: _____

I authorize release to : Hawai'i County Fire Commission
c/o Clerical Service Center
25 Aupuni Street, Suite 217
Hilo, HI 96720
Tel. No. (808) 961-8316 Fax No. (808) 933-1521

For the purpose of: _____

Date of incident: _____

Protected Health Information to be released:

✓ Complete medical record
✓ I further knowingly and voluntarily agree to the release of the following information. I understand _____will not
(Name of facility/physician)
release this information without my specific consent *(please initial each record to be disclosed, and cross through each record 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 hearby release _____, its
(Name of facility/physician)
employees, its agents and its staff physicians from all liability and all claims of any nature pertaining to the disclosure of information described above.

This consent may be revoked at any time, upon written notice from the person who has signed below, unless the action has already been taken. If not previously revoked, this consent will expire and terminate in six months from the date of signing.

Dated: _____

_____
(signature)
Print Name: _____

Relation to patient (if juvenile): _____

HFCFORM 2 – 12/22/04