

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

I hereby authorize _____ to allow the inspection,
(Name of facility/physician)
copying, and/or release of protected health information regarding:

Patient name: _____

Date of Birth: _____ SSN: _____

I authorize release to: Hawai`i Police Commission
 County of Hawai`i
 101 Aupuni St., Suite 313
 Hilo, HI 96720
 Tel. No. (808) 961-8412. FAX No. (808) 961-8563

For the purpose of: Investigation into a complaint of police misconduct.

Date of incident: _____

Protected Health Information to be released:

√ Complete medical record.

√ further knowingly and voluntarily agree to the release of the information listed below.

I understand _____ will not release this
(Name of facility/physician)
information without my specific consent.

(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 hereby release _____, its employees, its
(Name of facility/physician)

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.

Date: _____

Signature: _____

Print Name: _____

Signature of Parent or Guardian if patient is a juvenile: _____