AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

1) I, ____ ____________
(Print First and Last Name) (Date of Birth)

hereby authorize _______________________________________ to disclose protected health
(Name of physician, hospital, or other)
information related to my medical treatment.

2) This medical information may be disclosed to **Adoption Team Hawaii, Inc.**, or any of its employees, representatives or affiliates.

3) The information to be used or disclosed is any and all medical, health or other information including birth records, birth certificates, or other documentation pertaining to me, or to:

____________________________________ ____________________________________
(Name of Child) (Date of Birth) or (Expected Date of Birth)

4) Patient must initial for the following:

______ Psychiatric records/behavioral health/mental health records

______ AIDS/HIV/sexually transmitted disease related records

______ Drug and/or alcohol/substance abuse records

5) The information may be used in, or connection with, any proceedings for the adoption, or pertaining to the guardianship, custody or control, of the child I expect to place for adoption through **Adoption Team Hawaii, Inc.**, or its affiliates.

6) I understand that if I refuse to sign this authorization, the above-described health information will not be disclosed except as provided by law.

7) I understand that:
- I may revoke this authorization at any time by written notification to the party listed above. My revocation will have no effect on information that has been released under this authorization prior to receipt of my intent to revoke such authorization.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- I am entitled to a copy of this authorization upon signature.

This authorization expires on ____.
(Date)

Signature: ________________________________ Date Signed: ________________

If a personal representative executes this form, that representative warrants that he or she has the authority to sign this form on the basis of ____.
(Parent, Guardian, Power of Attorney, or other Authorized Representative)

___________________________________ ___________________________
(Signature) (Date)