Authorization To Release Medical Information to Spouse / Partner

Welcome to Advanced Reproductive Center of Hawai'i. Please take a moment to provide the information requested below so our team can better serve you.

Advanced Reproductive Center *of* Hawai'i

By signing below I hereby give my permission to Dr. Christopher Huang, Dr. Christina Arnett, and the Advanced Reproductive Center of Hawai'i staff to disclose my medical information, for any reason, to my spouse/partner listed below.

Unless I specify below under "Exclusion", I acknowledge that this includes any health information relating to testing, diagnosis and treatment for: AIDS/HIV, Sexually Transmitted Diseases, Alcohol/Drug Use and Developmental Disabilities.

This agreement will remain in effect until I advise the Advanced Reproductive Center of Hawai'i in writing.

PATIENT NAME	PATIENT SIGNATURE	DATE
SPOUSE / PARTNER NAME	SPOUSE / PARTNER SIGNATURE	DATE

Exclusion

_____ / _____ Initial here if you DO NOT authorize the release of any health information relating to testing, diagnosis and treatment for: AIDS/HIV, Sexually Transmitted Diseases, Alcohol/Drug Use and Developmental Disabilities.

Kapi'olani Medical Center for Women & Children
1319 Punahou Street, Suite 510, Honolulu, Hawai'i 96826
Ph: **(808) 949-6611**

Fax: **(808) 949-6610**
arch@archawaii.com