RELEASE FROM HOʻŌLA LĀHUI HAWAIʻI

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HOʻŌLA LĀHUI HAWAIʻI

☐Kapa'a Medical Clinic: (808) 240-0170 ~ Fax: (808) 822-9298
☐Kapa'a Dental Clinic (808) 240-0180 ~ Fax: (808) 822-9299
☐Waimea Medical Clinic (808) 240-0220 ~ Fax: (808) 338-1606
☐ Waimea Dental Clinic (808) 240-0150 ~ Fax: (808) 338-9646
☐Kapa'a Mobile Clinic: (808) 212-4888 ~ Fax: (808) 822-9298
☐Lihue Admin Phone: (808) 240-0100 ~ Fax: (808) 245-8867
☐Waimea Mobile Clinic (808) 652-6044 ~ Fax: (808) 338-1606

NOTE: All items with asterisk (*) must be completed for the authorization to be valid

I authorize Ho'ola Lahui Hawai'i (including all of the Provider agents and employees) to release protected health information of the following person:

Patient Name: _____ Birth Date: _____

Address: _____

Phone: _____ Fax: _____

TO: Name of recipient: _____

Address: _____

***Information authorized to be disclosed to Date(s) of Service:**

From: _____ **To:** _____

☐ Entire Health Record
☐ Billing Information
☐ AIDS, HIV, AIDS-Related Complex
☐ Alcohol and/or Mental health
☐ Behavioral and/or Mental Health
☐ Patient demographics, Income, documents, social security, number & may include prescription information
☐ Confidential Title X
☐ Other (Please specify below):

_____

_____

***Purpose(s) of Use and/or Disclosure**

☐ Legal Purpose
☐ At Request of Patient
☐ Continuity of Care
☐ Other (Please specify below):

_____

_____

_____

_____

_____

_____

_____

_____

_____ (Initial) I agree to the release of the information checked above related to the diagnosis, evaluation or treatment. (Unless I specifically agree, the information will not be disclosed).

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*Unless otherwise revoked, this authorization will expire on the following date or event: _____

If a date or event is not specified, this authorization will expire one year from my date of signature below.

A reasonable fee may be charged by the Provider 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 Provider will not condition my 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 giving written notice of my revocation to the above-named Provider. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization and there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, when 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 this authorization may be re-disclosed by the Recipient without my permission and may no longer be protected under HIPAA privacy regulations.

***Requester's Signature:** _____

Patient or Legally authorized representative

To be completed only if requester is not the named patient:

*Printed Name: _____

*Relationship to Patient: _____

Complete only if requester is not the Patient

*Date: _____

If the requester is not the Patient, please provide a court order or other documentation evidencing the authority of the requester to act on the Patient's behalf.

Authorization Reviewed By: _____

Printed Name:_____ Date: _____