Release From HLH

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HOʻŌLA LĀHUI HAWAIʻI

P.O. Box 3990; Līhuʻe, Hawaiʻi

Phone: 808.240.0112 Fax: 808-245-8867

Kapaʻa Clinic Phone: 808-240-0170 Fax: 808-822-9298

Waimea Clinic Phone: 808-240-0140 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's agents and employees) to release protected health information of the following person:

*Patient Name: ________________________________Birth Date: ______________________

Address: ____

Phone: ____

To: *Name of Recipient: ____

Address: ____

*Information authorized to be disclosed to Date(s) of Service: From____________________To_____________________ _______ Entire Health Record _______ Billing Information _______ Dental X-Rays _______ Patient demographics, income documents, social security number, & may include prescription information _______ Other (Please specify)____________________ _______ AIDS, HIV, AIDS-Related Complex _______ Alcohol and/or Drug Abuse _______ Behavioral and/or Mental Health	*Purposes of Use and/or Disclosure: _______ Legal Purpose _______ At Request of Patient _______ Continuity of Care _______ Other (Please specify) _______________________________

_______ (initial) I agree to the release of the information checked above related to 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 the 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 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________________________