AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Release To HLH

HOʻŌLA LĀHUI HAWAIʻI

- *P.O. Box 3990; Līhuʻe, HI 96766*
  Phone: 808-240-0112 Fax: 808-245-8867
- *Kapaʻa Clinic – 4800D Kawaihau Road, Kapaʻa, HI 96746*
  Phone: 808-240-0170 Fax: 808-822-9298
- *Waimea Clinic – 4643B Waimea Canyon Drive, Waimea, HI 96796*
  Mailing Address: P. O. Box 487, Waimea, HI 96796
  Phone: 808-240-0140 Fax: 808-338-1606

Note: all items with asterisk (*) must be completed for the authorization to be valid

I authorize ____

Address____

____

Phone____

to release protected health information of the following person:

*Patient Name: ______________________________Birth Date: ____________________

To: Name of Recipient: **Ho'ola Lahui Hawai'i** (check appropriate address above)
Provider:____

*Information authorized to be disclosed to Date(s) of Service	*Purposes of Use and/or Disclosure:
From________________To____________________	______ Legal Purpose
______ Entire Health Record	______ At Request of Patient
______ Billing Information	______ Continuity of Care
______ Dental X-Rays	______ Other (Please specify)
______ Other (Please specify)________________	______________________________
______ AIDS, HIV, AIDS-Related Complex	
______ Alcohol and/or Drug Abuse	
______ Behavioral and/or Mental Health	

______ (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.

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______________________