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*
  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)

*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
_____ AIDS, HIV, AIDS-Related Complex	_____ Other (Please specify)
_____ Alcohol and/or Drug Abuse	_____
_____ Behavioral and/or Mental Health	
_____ 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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HOʻŌLA LĀHUI HAWAIʻI

*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_____