Hawaii Health Systems Corporation
79-1019 Haukapila Street
Kealakekua, HI 96750
Ph: (808) 322-9311
Fax: (808) 322-0845
www.hhsc.org

AUTHORIZATION TO USE/DISCLOSE PATIENT HEALTH INFORMATION

I authorize ______________________ (FACILITY NAME) ***to release/obtain/inspect protected health information of:***

Patient Name: ______________________

Birthdate: ____________ Phone #: ____________ Medical Record #: ____________

TO (Name or Institution): ______________________

Address: ______________________ City, State, Zip ____________

Information to be disclosed/obtained:	**Purposes for Use and/or Disclosure:**
Date(s) of Service: ____________	☐ At the request of the individual
☐ Discharge Summary ☐ ER report	☐ Legal Purposes
☐ History & Physical ☐ Laboratory Results	☐ Insurance
☐ Consults ☐ X-Ray/Imaging Reports	☐ Physician follow-up
☐ Operative Reports ☐ Entire Record (add'l fee may be applicable)	☐ Other: ____________
☐ Other:	____________
Please specify: ____________	____________

1. The types of information below *CANNOT* be released without specific authorization and knowledge. Please initial acknowledging that the KCH has authorization to release the following protected health information that may contain the following:

   (Pt's initials) ________ *ALCOHOL and/or DRUG ABUSE TREATMENT RECORDS*

   (Pt's initials) ________ *MENTAL HEALTH TREATMENT RECORDS*

   (Pt's initials) ________ *SEXUALLY TRANSMITTED DISEASES INCLUDING AIDS & HIV TESTING RECORDS*

2. **Right to revoke authorization:** I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Kona Community Hospital Medical Record Dept. 79-1019 Haukapila Street, Kealakekua, HI 96750 I understand that the revocation will not apply to information that has already been released or used in response to this authorization. I understand that the revocation will not apply to my insurance company if this 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.

3. **Expiration:** Unless sooner revoked, this authorization will expire on the following date, event, or condition:____________ If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

4. **Voluntary Disclosure, not a condition to treatment:** I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. Signing this authorization is not a condition to treatment. I cannot be denied treatment even if I refuse to sign this authorization.

5. **Information is subject to unauthorized re-disclosure:** I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and once re-disclosed, the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Kona Community Hospital Medical Record Department.

6. **Remuneration to Kona Community Hospital:** ________ Applicable ________ Not Applicable This authorization is for the use or disclosure of information by Kona Community Hospital for purposes of marketing that involves direct or indirect remuneration to Kona Community Hospital from another person or entity.

I have read all of the above, and I understand the full meaning of this authorization. I am signing this authorization voluntarily, and under no coercion.

Patient's signature: ______________________ **Date:** ____________

Name of Patient or Designated Patient Representative: ______________________

Relationship to Patient: ______________________

Witness Signature: ______________________ Date: ____________

- *Identity of authorized signer verified by:* ____ *State ID* ____ *Driver's license* ____ *Other* ____________
- *Copy "designated patient representative" documentation obtained for permanent record (check one):* ____ *yes* ____ *no*

FORM 354-0525 Rev. 4/04 ORIGINAL: HOSPITAL COPY: PATIENT/PATIENT REPRESENTATIVE