The Queens Medical Center
Medical Records Department
1301 Punchbowl Street
Honolulu, Hawaii 96813
(808) 547-4400

RE: Subpoena

This is to inform you that we do not accept out of state subpoenas. We will gladly accept and comply with a subpoena issued through a court of the State of Hawaii and served by anyone legally authorized to serve a subpoena in the State of Hawaii.

As an alternative, we can act upon a valid authorization. However, please be aware that should you decide to go this route, your request will not be treated as a subpoena, but as a regular request. Records produced will not be authenticated by a notary as we do not offer this service.

Should you decide to reissue this subpoena through a court of the State of Hawaii, please keep in mind that in accordance with the provisions of the federal privacy rule*, we may disclose protected health information in response to a subpoena only if we receive a written statement and accompanying documentation that demonstrates:

(1) The party seeking the protected health information has made reasonable efforts to ensure that the individual who is the subject of the information has been given notice of the request in accordance with Section 164.512(e)(iii), or

(2) The party seeking the protected health information has made reasonable efforts to secure a qualified protective order in accordance with Section 164.512 e)(iv) and (v).

In accordance with the above privacy regulations, we require the following in order to comply with a subpoena:

A. The completion of the accompanying Statement of Appropriate Notice, AND a copy of the notice;
B. The completion of the accompnying Qualified Protective order, AND a copy of the order;
C. A valid authorization signed by the individual whose records are being sought, or signed by his/her legal representative; or
D. A valid court order.

Please know, that should the patient's records be found to contain federal and/or state

protected information, the only options for us to release the information would be a court order or a signed HIPAA compliant authorization which puts the patient on notice as to the exact type of information that will be released.

Pursuant to the requirements of Rule 45 of the Hawaii Rules of Civil Procedure or other applicable rules, this constitutes our notice of objection to the subpoena. We will, of course, act upon the subpoena once we have received the appropriate documents.

We apologize for any inconvenience this may cause. Should you have any questions, please contact Marilyn Agas at (808) 547-4400 or (808) 547-4518, Monday through Friday, 8:00 a.m. until 4:00 p.m., Hawaii Pacific Time.

Sincerely,

Laura Shannon-Madeja

Laura Shannon-Madeja
Release of Information Coordinator
Medical Records.

*Standards for Privacy of Identifiable Health Information (HIPAA), 45 CFR, Subtitle A. Subchapter C, Section 164.512(d)(e)(f)

Enc: Statement of Appropriate Notice
Qualified Protective Order
QMC Authorization form

Statement of Appropriate Notice

Re: *{PLAINTIFF}
V.
*{DEFENDANT}

Case #: *{CASENUM}

I declare under penalty of perjury that all of the following have been completed.

1. Either:

   a. *[Initial here]*_____I have provided written notice to the individual or the legal representative of the individual who is the subject of the protected health information that is requested that I am requesting the information. A copy of the notice is enclosed. It was provided to the individual on *[date]*_____ by *[describe method, e.g., personal service]*
   _____.

   b. *[Initial here]*_____I have made a good faith attempt to provide written notice to the individual who is the subject of the protected health information that is requested or, if the individual's location is unknown, to mail a notice to the individual's last known address, by *[describe efforts to provide notice]*
   _____.

2. The notice included sufficient information about the litigation or proceeding, in which the protected health information is requested, to permit the individual to raise an objection to the court or administrative tribunal, and

3. The time for the individual to raise objections to the court or administrative tribunal has elapsed, and

   a. No objections were filed, or

   b. All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

_____ _____
Signature Date

_____
Printed Name

Statement of Qualified Protective Order

Re: *{PLAINTIFF}
V.
*{DEFENDANT}

Case #: *{CASENUM}

A Qualified Protective Order is an order of the court or an administrative tribunal or a stipulat on by the parties to the litigation or administrative proceeding that:

a. Prohibits the parties from using or disclosing the protected health informatic n for any purpose other than the litigation or proceeding for which such information was equested, and

b. Requires the return to The Queen's Medical Center or destruction of the protec ed health information (including all copies made) at the end of the litigation or proceedin

I declare under penalty of perjury that one of the following has been completed (please initial one)

_____ The parties to the dispute giving rise to the request for the information have a greed to a qualified protective order covering all of the health information requested, and have presented it to the court or administrative tribunal with jurisdiction over the lispute (a copy of the order is enclosed), or

_____ The undersigned has requested a qualified protective order from such court or administrative tribunal. A copy of the petition is enclosed.

_____ _____
Signature Date

_____
Printed Name

THE QUEEN'S MEDICAL CENTER

Medical Records Department • 1301 Punchbowl Street • Honolulu, Hawaii 96813
Phone: (808) 538-9011 • (808) 547-4400 • Fax: (808) 537-7806 • (808) 547-4907

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize * QUEEN'S MEDICAL CENTER *to release/obtain the protected health information of*
*(*Provider/Health care facility)*

*Patient Name: _____ Birthdate: _____

Address: _____ Phone #: _____

To: *Name or Institution: _____

Address: _____ City, State, Zip: _____

*Information to be disclosed:

Date(s) of Service: _____

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consults
- ☐ Operative Reports
- ☐ Other:
- ☐ ER report
- ☐ Laboratory Results
- ☐ X-Ray/Imaging Reports
- ☐ Entire Record

Please specify: _____

*Purposes for Use and/or Disclosure:

- ☐ At the request of the individual
- ☐ Legal Purposes
- ☐ Insurance
- ☐ Physician follow-up
- ☐ Other: _____

_____ **(Initial) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services. (If I do not specifically agree, this information will not be disclosed):**

***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.

This authorization is voluntary. I understand that I can refuse to sign this authorization and The Queen's Medical Center (QMC) will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: (i) research-related treatment; or (ii) health care provided solely for disclosure to a third party or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

I understand that I may revoke this authorization at any time by notifying the QMC Medical Records Department, in writing, of my revocation. This is described in the QMC Notice of Privacy Practices. I understand that the revocation will not apply to any information that already was released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I hereby release The Queen's Medical Center from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by The Queen's Medical Center.

*Signature: _____ * _____
Patient or Personal Representative — Print Name

*Relationship: _____ _____
(Relationship to Patient) *Complete only if requestor is not patient* — Date

*Items that MUST be completed for authorization to be valid.

FORM 3312 Rev 10/09

Distribution: White — Medical Records • Yellow — Patient