HAWAII HEALTH SYSTEMS CORPORATION
Quality Healthcare For All

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Hawaii Health Systems Corporation ("HHSC") to disclose my individually identifiable health information ("Information" or "Medical Records") as described below. I understand this authorization is voluntary.

PATIENT NAME: _____ DATE OF BIRTH: _____

Other name(s) used: _____

Address: _____

Telephone: Work: _____ Home: _____ Mobile: _____

1. Person/ Entity providing the Information: _____

Purpose for disclosure:	I request the following format: ☐ Review Only
☐ Physician Follow-up ☐ Insurance ☐ Legal Purpose ☐ Patient Request ☐ Other (specify): _____ _____ _____	Fees may apply: ☐ Fax (unsecured) ☐ Email (unencrypted) ☐ Paper Copy ☐ Electronic Copy (unencrypted CD, USB drive or other electronic format) ☐ Other (specify): _____ ☐ Submit to Person / Entity: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____ Fax #: _____ Email address: _____

2. Select from the following (check as many as apply) for services provided during the period of _____/_____/_____ to _____/_____/_____

☐ Billing Records ☐ Complete record (additional fee may apply) ☐ Consultation Reports ☐ Discharge Summary ☐ Echocardiogram Reports ☐ EKG Reports	☐ ER Reports ☐ Photography, Videotapes, Digital or other images ☐ History and Physical Examination ☐ Laboratory Reports ☐ Pathology Reports ☐ Operative Reports	☐ Psychotherapy Notes ** (<u>separate</u> authorization required) ☐ Progress Notes ☐ Treadmill Reports ☐ Verification of Birth	☐ X-ray Films/Images ☐ X-ray Reports ☐ Other Radiology Films / Images (specify) ☐ Other Radiology Reports (specify)	☐ Other (specify): _____ _____ _____ _____ _____ _____ _____

3. *SUBSTANCE USE DISORDER RECORDS: *This section is applicable only if a Medical Record includes substance use disorder records received from a substance use disorder treatment facility or program.

I understand that my Medical Records may include substance use disorder records received from a substance use disorder treatment facility or program. Substance use disorder records are protected under federal law and cannot be disclosed without my written consent, unless otherwise permitted by federal law. Any substance use disorder records in your Medical Records <u>WILL NOT</u> be released, <u>UNLESS</u> you initial below.

Initials: ☐ I understand that my Medical Records may include substance use disorder records received from a substance use disorder treatment facility or program. I hereby authorize HHSC to release such substance use disorder records to the person or entity identified in this authorization.

Any disclosure of substance use disorder records shall be accompanied by a notice informing the recipient that further disclosure or re-disclosure of such substance use disorder records is prohibited unless permitted by your written consent or otherwise permitted by federal law.

4. I understand if the person or entity authorized to receive the Information, except for substance use disorder records, is not a health plan or health care provider, the released Information may no longer be protected by federal privacy regulations.

ROI:

/ /

HM:

5. HHSC, its employees, officers, and physicians are released from any legal responsibility or liability for releasing the requested Information as authorized.

6. My initials indicate that I have read and agree to the following:

   a. Initials: ____ I understand this authorization will expire six months from the date signed below or upon the following event or condition _____, unless revoked earlier.

   b. Initials: ____ I understand I may revoke this authorization at any time by notifying this facility in writing. I also understand that revoking this authorization will not apply to any Information already released by this facility before the facility received the revocation. (See our Notice of Privacy Practices for Instructions).

   c. Initials: ____ I understand that this facility reserves the right to collect reasonable fees for the copies I have requested.

7. If I request HHSC to transmit my Information by unencrypted email or other unsecured manner, I acknowledge that the risks include, but are not limited to: (1) Information may be intercepted, altered, forwarded or used without detection or authorization, (2) Information may be circulated, forwarded and stored in paper and electronic forms, (3) email may be sent to the wrong address, (4) unsecured transmission may spread computer viruses, and (5) email may be lost. I understand these risks and consent to the transmission of my Information by unencrypted email or other unsecured manner. By initialing here ____, I confirm that I hereby release HHSC from all liability and claims of any nature whatsoever pertaining to the transmission of my Information by unencrypted email or other unsecured manner.

8. I hereby release HHSC from all liability and all claims of any nature whatsoever pertaining to the use and disclosure of Information, or of any professional opinions, findings, or recommendation as contained in the records released to or by HHSC. I understand that HHSC is NOT responsible for lost or misplaced copies (in paper or electronic form, such as CDs, thumb drives etc.), and it is my responsibility to handle them with care.

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

Signature: _____ Print Name: _____ Date: _____ Time: _____
Patient or Legal Representative

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

Office Use Only:

Witness Signature: _____ Print Name: _____ Date: _____ Time: _____

- Identity of authorized signer verified by: ☐ State ID ☐ Driver's license ☐ Other _____
- Copy of "designated patient representative" documentation obtained for permanent record (check one): ☐ Yes ☐ No

ID verification signature: _____ Print Name: _____ Date: _____ Time: _____

ROI:

/ /

HM: