Hilo Benioff Medical Center

Hilo Benioff Medical Center
Hawaii Health Systems Corporation
1190 Waianuenue Avenue, Hilo, HI 96720
Phone: (808) 932-3816
Fax: (808) 935-1889
www.hhsc.org

AUTHORIZATION TO USE/DISCLOSE PATIENT HEALTH INFORMATION

I authorize HILO BENIOFF MEDICAL CENTER *to release/obtain/inspect protected health information of:*
(Facility Name)

1. Patient Name: _____

   Birthdate: _____ Phone #: _____ Medical Record #: _____

   Email address is required for ALL imaging requests: _____

   TO (Name or Facility): _____

   Address: _____ Facility Phone #: _____

   City, State, Zip Code: _____

2. **Information to be disclosed/obtained**:

Specify imaging exam(s) and/or visit dates:	Mark box below if requesting ☐ Imaging Reports ONLY	**Purposes for Use and/or Disclosure:** ☐ At the request of the individual ☐ Legal Purposes ☐ Insurance ☐ Physician follow-up ☐ Other:

3. **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 the Hilo Benioff Medical Center Imaging Department. 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.

4. **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 one year.

5. 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.

6. **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 the Medical Records Department at (808) 974-6795.

7. 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 or Patient Representative's signature: _____ **Date:** _____

Print Name of Patient or Designated Patient Representative: _____

Relationship to Patient: ☐ Self ☐ Other: _____

For Office Use Only:

Witness Signature: _____ Print Name: _____

- 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

PowerShare instructions provided? ☐ YES ☐ NO