MOLOKAI GENERAL HOSPITAL

Medical Records Department ■ P.O. Box 408 ■ Kaunakakai, HI 96748 ■ Phone: (808) 553-3114 ■ Fax: (808) 553-3164

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I authorize * _____to release the protected health information of:
(*Facility Name)

*Patient Name: _____

Birth date: _____ Phone #: (_____) _____

To: *Name or Institution: _____

Address: _____ City, State, Zip: _____

*Information to be disclosed:	*Purpose for Use and/or disclosure:
Date of Service: _____ ☐ Discharge Summary ☐ ER Report ☐ History & Physical ☐ Laboratory Results ☐ Consults ☐ X-Ray/Imaging Reports ☐ Operative Reports ☐ Entire Record ☐ Other: Please Specify: _____	☐ 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 Molokai General Hospital (MGH) 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 MGH Medical Records Department, in writing, of my revocation. This is described in the MGH 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 Molokai General Hospital from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Molokai General Hospital.

*Requestor: _____ *_____
Signature Print Name

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

* Items that MUST be completed for authorization to be valid