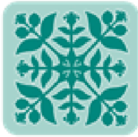

NORTH HAWAII COMMUNITY HOSPITAL

AN AFFILIATE OF THE QUEEN'S HEALTH SYSTEMS

Medical Records Department ▪ 1301 Punchbowl St. ▪ Honolulu, HI 96813 ▪ Phone: (808) 881-4652 ▪ Fax: (808) 881-4649

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

*Patient Name: ____ Birthdate: ____________________

Address: ____ Phone #: _____________________

To: *Name or Institution: ____

Address: _________________________________ City, State, Zip: ______________________________________

*Information to be disclosed: Date(s) of Service: ______________________________ ☐ Discharge Summary ☐ ER report ☐ History & Physical ☐ Laboratory Results ☐ Consults ☐ X-Ray/Imaging Reports ☐ Operative Reports ☐ Entire Record ☐ Other: 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 alcohol and/or drug abuse treatment information. (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 North Hawaii Community Hospital (NHCH) 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 NHCH Medical Records Department, in writing, of my revocation. This is described in The Queen's Health Systems 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 North Hawaii Community 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 North Hawaii Community Hospital.

*Requestor: ____ *______________________________________
Signature of Patient or Authorized 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