MOLOKAI GENERAL HOSPITAL

Rural Health Clinic • P.O. Box 408 • Kaunakakai, HI 96748 • Phone: (808) 553-3121 • Fax: (808) 553-3112

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I authorize ______________________________ ______________________
Facility Name/Physician Name Address

______________________ ______________________
Phone Number Fax Number

to release the protected health information of:

Patient Name: ______________________ Birth date: ______________

Phone No: ______________ Current Insurance ______________________

To: *Molokai General Hospital Outpatient Clinic the office of: ☐ William L. Thomas Jr. M.D. ☐ Naomi L. Burr M.D.

*Information to be disclosed:	* Purposes for Use and/or Disclosure:
Date(s) of Service: ______________	☐ At the request of the individual
☐ Discharge Summary ☐ ER Reports	☐ Legal Purposes
☐ History & Physical ☐ Laboratory Results	☐ Insurance
☐ Consults ☐ Operative Reports	☐ Physician Follow-up
☐ X-Ray/Imaging Records ☐ Entire Record	☐ Other: ______________
☐ Other (Please specify): ______________	

______ (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 car 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, or 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.**

For Office Use Only

Request Received By: ______________ Date: ________
MD Approval By: ______________ Date: ________
Patient Notified By: ______________ Date: ________