THE QUEEN'S HEALTH SYSTEMS

Punchbowl • West Oahu
Medical Records Department • 1301 Punchbowl Street • Honolulu, Hawaii 96813
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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize _____ *to release the protected health information of:*
(Health Care Facility/Provider - ie Queen's Medical Center)

Patient Name: _____ Birthdate: _____

Address: _____ City, State, Zip: _____

Phone #: _____

Release To: Name, Institution or Self: _____

Address: _____ City, State, Zip: _____

Phone #: _____ Fax #: _____

Information to be disclosed:	Purposes for Use and/or Disclosure:
Date(s) of Service: _____	
☐ Discharge Summary ☐ History & Physical ☐ Consults ☐ Operative Reports ☐ X-Ray/Imaging Reports ☐ Laboratory Results ☐ ER Report ☐ Progress Notes ☐ Flowsheets	☐ At the Request of the Individual ☐ Insurance ☐ Physician Follow Up ☐ Attorney Request
☐ Other, please specify: _____	☐ Other, please specify: _____

_____ **(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.

Requestor: _____ _____
Signature of Patient or Authorized Representative — Print Name

Relationship: _____ _____
If signed by someone other than Patient, State Relationship — Date

This authorization is voluntary. I understand that I can refuse to sign this authorization and the facility 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 facility's Medical Records Department or The Queen's Health Systems' Privacy Officer, 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 the facility 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 the facility.