THE QUEEN'S HEALTH SYSTEMS

Molokai General Hospital
Medical Records Department • PO Box 408 • Kaunakakai, HI 96748
Phone (808) 553-3114• FAX: (808) 553-3164

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: ____ Phone #: ____________________

*Release To: *Name or Institution*: ____

Address: ________________________________ City, State, Zip: ______________________________

Phone #: _____________________________ Fax #: ____

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

* Items that MUST be completed for authorization to be valid