ISLAND URGENTCARE

Hawaii Kai • Kaka'ako • Kapahulu • Pearl Kai
Phone: (808)735-0007
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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

1. I authorize * ____Island Urgent Care___ to release the **protected health information** of the following:
   ***Patient Name**: ______________________________________ Date of Birth: _____________ SSN: _____________
   Address: ____________________________________ City: _____________________ State: ______ Zip: __________
   Phone: ______________________ Email: ____
2. To: ***Recipient** (E.g.: PCP, specialist, family member):____
   Address: ____________________________________ City: ____________________ State: _______ Zip: __________
   Phone: ____________________ Fax: ___________________ Email: ______________________________________
3. ***Information to be disclosed:**
   Date(s) of Service: ___________________
   □ Entire Medical Record
   □ Other (Please specify):
   ____
4. ***Purpose of use and/or disclosure:**
   □ Legal Purposes
   □ At request of patient
   □ Other (Please specify):
   ____

5. **VISITOR AUTH: I authorize (insert name(s))** ____ to be present in the exam room during my medical care today. I understand that this authorization allows the listed person(s) access to the health information that may be discussed during the medical exam.

NOTE: Visitors will NOT be authorized to receive additional information (outside of the in-room discussion) unless they are also listed in section 2 as 'recipient'.

____ (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 (*unless I specifically agree, the information will not be disclosed*).

6. ***Unless otherwise revoked, this authorization will expire on the following date:** ________________________
If a date is not specified, this authorization will expire one year from my date of signature below.
A reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.
This authorization is voluntary. I understand that the above-named healthcare provider(s) or health plan(s) will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed by law.
I understand that I may revoke this authorization at any time by notifying the above-named provider(s) and/or health plan(s), in writing, of my revocation. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization and there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the right to contest a claim under my policy or my policy itself.
I understand that the health information released under this authorization may be re-disclosed by the recipient and my no longer be protected under the federal privacy regulations.
I release the above-named health care provider from all liability and claims whatsoever pertaining to the disclosure of information as contained in the records released pursuant of this authorization.

7. ***Requestor's Signature**: ____ ***Date**: _________________________
Patient/Legally authorized representative

***Printed Name:** ______________________________________ Relationship to Patient: ___________________________
(Complete only if requestor is not patient)

***Items must be completed for authorization to be valid**