Authorization for Use and Disclosure of Medical Information

I, _____ Birth Date: _____
(print patient name)

authorize _____
(**NAME OF PREVIOUS PHYSICIAN OR MEDICAL FACILITY THAT WE ARE REQUESTING RECORDS FROM**)

to release copies of the following *medical records pertaining to me:

	***Information to be Disclosed**	***Purpose of Use and/or Disclosure**
	Date(s) of Service:	
☐	Entire Medical Record	Legal purposes
☐	Medical Bills	At request of patient
☐	Other (please specify):	Other:

to be forwarded to:

Physician Name: _____
University, Clinical, Educational & Research Associates for Continuing Medical Care
Medical Specialty Clinic – Internal Medicine
550 S. Beretania Street, Ste. 510
Honolulu, HI 96813
Phone: (808) 536-3773 Fax: (808) 536-3774

____ (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, 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.

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 health care provider(s) and /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 the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under the federal privacy regulations.
I release the above-named provider(s) and/or health plan(s) from all liability and all claims whatsoever pertaining to the disclosure of information as contained in the records released pursuant to this authorization.

* Requestor's signature: _____ * Printed Name: _____
Patient or legally-authorized representative

*Relationship to Patient: _____ * Date: _____

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

This form has been developed as a collaborative effort among the Hawaii State Bar Association and the Hawaii HIPAA Readiness Collaborative, including The Queen's Medical Center, Hawaii Pacific Health, St. Francis Medical Center and Hawaii Health Systems Corporation.