Request & Authorization for Release of Your Private Protected Health Information

Please carefully read & understand the following information before you complete & sign this release. Your signature at the bottom of this page is undeniable proof that you have done so.

The Health Insurance Portability and Accountability Act (HIPAA) and its regulations (45 CFR 164.508) prohibit us and other healthcare providers, health insurers and medical centers from releasing your health information without your consent. If you authorize us to release some or all of your healthcare information to a person or organization not covered by HIPAA, it is highly possible that the healthcare information we release will no longer be private or protected or confidential and may be distributed to others. Examples of persons and organizations not covered by HIPAA are lawyers and insurance companies (e.g., auto or life insurance). You may refuse to sign this authorization and it will not affect the treatment you receive from UHP and its providers in any way – we will still offer you the same level of care, courtesy, and professionalism, After you sign this request & authorization, you may revoke it at any time, but you must do so in writing to us. Our receipt of your signed revocation will not apply to information previously released but will cause us not to release further information. In accordance with the Hawaii Health Care Privacy Harmonization Act(HRS §323B), any medical records pertaining to HIV/AIDS related information, genetic testing information, mental health information, and/or drug and alcohol treatment information is no longer subject to special state privacy rules and may be included in the information released pursuant to this request & authorization, except as to information protected under 42 CFR Part2, which may not be disclosed or redisclosed without my authorization.

_____ _____ _____/_____/_____

Name of Patient - First & Last Name | Former Legal Name | DOB (MM/DD/YYYY)

Provider_____ or Clinic Location_____

Dates of service: _____ to _____ ☐ Progress notes ☐ Lab reports ☐ Consultations ☐ Pathology

☐ Operative Report ☐ Radiology Reports ☐ Billing Summary ☐ Other _____

Name(s) of person or party to receive my information: _____

Phone number of person or party to receive my information: _____

The purpose of this disclosure is:

☐ Change of Insurance or Physician ☐ Continuity of Care ☐ Other (Specify): _____

This authorization to use or disclose your health information will expire according to the following. You can specify below (Please check one), or if an expiration date or event is not specified, this authorization will expire one year from the date of signature.

☐ on this **date** (indicate when you want this authorization to expire) _____

☐ upon this specific **event** (describe event) _____

☐ when I revoke this authorization to UHP in writing._____

There is a $0.50 per page fee for records and a separate fee for certified mail receipt postage.

NO Cost for requests directly sent to a healthcare provider. Minimum of 10 business day processing time on requests.

I have read and understand this information. I am the patient or I am authorized to act on behalf of the patient to sign this document authorizing the use or disclosure of Protected Health Information under the above terms.

Date: _____ Phone number: _____ Email:_____

Relationship (If signed by other than patient): _____ **Signature:** _____

***If your relationship to the patient is not that of a parent to a minor child, you must show documentation of your legal right to make this request (e.g. power of attorney, court-appointed guardianship, surrogate, etc.)**

I would like to receive my records from UHP in the following manner:

☐ Via USPS Mail to the following address: ☐ Via Fax to the following number: _____

_____ ☐ Via Email (encrypted): _____

_____

☐ Via **Pick Up** at UHP's Executive Office at 677 Ala Moana Blvd, Suite 1001 ■ Honolulu, HI 96813
You must notify us of the first and last name of the individual designated to pick up your records and indicate their relationship to you in the space below. If you are picking up your medical records yourself, please write "Self".

_____ _____
Name of designated person Relationship

☐ Via another form or format; Please contact the HIM department to discuss arrangements.
It is recommended that records over 150 pages be certified mailed via USPS or picked up in person by you or your designated proxy.

Return form By Mail to: UHP Medical Records
677 Ala Moana Blvd., Suite 1001
Honolulu, HI 96813

Fax to: (808) 447-3943
Attn.: HIM Specialist
By Email medrecs@ucera.org

Any Questions? If you have any questions related to this form or your medical records request, or for follow-up information regarding your request, please call HIM department at (808) 469-4924.

For UHP Use Only

Date Received: _____ Practice Location: _____

Notes: _____