University Health Partners of Hawai'i

The faculty practice of the John A. Burns School of Medicine

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Information:	Patient Name		Maiden/Other legal name
	Date of Birth	Last 4 of SSN#	Phone
Record Holder: *Who has the information you want released?*	Name of Clinic/ Provider / Person		
	Street Address/ City / State / Zip		
	Phone	Fax:	
Release Records to: *Who do you want to receive records? Where do you want records sent?*	Name of Clinic/ Provider / Person		
	Street Address/ City / State / Zip		
	Phone	Fax:	
Purpose:	☐ Continued Care ☐ Legal ☐ Personal ☐ Insurance ☐ Disability Other (please specify):		
Health Information to be Released: *What do you want to be released?*	Routine Record Sets: - **For dates of service:** _____ ☐ **Clinic visit** (office notes, procedure notes, operative notes, lab, diagnostic and radiology reports) ☐ **Other Records** - *Please Specify Type:* _____ ☐ **Billing Records**		
Authorization:	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 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 layers and insurance companies (e.g., auto or life insurance). You may refuse to sign this authorication and it will not affect the treatment you receive from UHP of Hawaii 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 , genetic testing, mental health, 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.		

_____ _____ _____ _____ AM/PM

Signature of Patient or Authorized Representative | Print Name | Date | Time

Relationship (If signed by other than Patient)

***If your relationship to the patient is not that of a parent to a minor child, you must show documentation of your legal right. Ex POA or other document**

Unless otherwise revoked this authorization will expire 12 months after the date of signing this form.

* Staff Use	Info Released By:	On Date: