

Authorization for Disclosure of Protected Health Information to Patient Portal

I hereby authorize the Hawaii Health Services Corporation East Hawaii Region (EH), which includes the hospitals above, to use/disclose my individually identifiable health record to the EH Patient Portal.

 **Please write legibly and complete all fields below, illegible or blank entries will not be considered.**

First Name:	Last Name:	MI:
Date of Birth:	Preferred Phone Number: <small>*Must be a valid number to contact you if there are questions regarding your account*</small>	
E-Mail Address:		

Initial **all** terms indicating you understand and agree to each statement.

- I will not use the web portal in any way that would violate local, state or federal laws.
- I will not transmit materials that are obscene, defamatory, abusive, slanderous or otherwise likely to result in harm to others
- I will not introduce intentionally any malicious computer code or take any other action that could compromise the security of the computer system.
- EH is not responsible for a breach of this sensitive information if I use a computer workstation or device that could be or is compromised.
- This authorization MAY BE REVOKED by either me or EH at any time. If EH revokes, it will notify me.
- Should I, for whatever reason, gain access to another person's health records, I will not read such information and I will report the problem immediately to EH.
- I am responsible to protect my own log in and password information, and that EH will not be held liable for breaches of confidentiality arising from unauthorized disclosure of such information.
- I must agree to the Terms and Conditions on Patient Portal upon my initial and subsequent log-ins, or I will not be granted access.

I MAY DECLINE TO SIGN THIS AUTHORIZATION. EH will not refuse to treat me if I do not sign this authorization.

Date

Signature of Patient

Office Use Only

Patient Representative: _____

I have authenticated the identity of the person named on this authorization form:

Drivers License State ID Other (Specify):

Patient Portal Access Granted : Yes No

Comment:

Place Inpatient Identifier here or fill in patient medical record number

MRN: