MY HOSPITAL Hilo Medical Center MY COMMUNITY

Hale Hoòla Hamakua

Ka'u Hospital

Ka Hale Ola Ka'u

P.O. BOX 40 PAHALA, HAWAII 96777

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:** *Must be a valid number to contact you if there are questions regarding your account*	
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: