Hilo Medical Center
Hawaii Health Systems Corporation
1190 Waianuenue Avenue, Hilo, HI 96720
www.hhsc.org
Phone: (808) 932-3816
Fax: (808) 935-1889

AUTHORIZATION TO USE/DISCLOSE PATIENT HEALTH INFORMATION

I authorize HILO MEDICAL CENTER *to release/obtain/inspect protected health information of:*
(Facility Name)

Patient Name: _____

Birthdate: _____ Phone #: _____ Medical Record #: _____

TO (Name or Institution): _____

Address: _____ City, State, Zip Code: _____

Information to be disclosed/obtained:	Purposes for Use and/or Disclosure:
Date(s) of Service: _____	☐ At the request of the individual
☐ Discharge Summary ☐ ER report	☐ Legal Purposes
☐ History & Physical ☐ Laboratory Results	☐ Insurance
☐ Consults ☐ **Imaging Reports** and/or ☐ **Imaging Films (CD)**	☐ Physician follow-up
☐ Operative Reports ☐ Entire Record (additional fee may be applicable)	☐ Other: _____
☐ Other: _____	
Please specify:	

The types of information below shall not be released by Hilo Medical Center without my specific authorization. By initialing below, I hereby specifically authorize Hilo Medical Center to release the following protected health information in my record:

(Patient's initials) _____ ALCOHOL and/or DRUG ABUSE TREATMENT RECORDS
(Patient's initials) _____ MENTAL HEALTH TREATMENT RECORDS
(Patient's initials) _____ SEXUALLY TRANSMITTED DISEASES INCLUDING AIDS & HIV TESTING RECORDS

Right to revoke authorization: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Hilo Medical Center Medical Records Department. I understand that the revocation will not apply to information that has already been released or used in response to this authorization. I understand that the revocation will not apply to my insurance company if this authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the right to contest a claim under my policy or my policy itself.

Expiration: Unless sooner revoked, this authorization will expire on the following date, event, or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Voluntary Disclosure, not a condition to treatment: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. Signing this authorization is not a condition to treatment. I cannot be denied treatment even if I refuse to sign this authorization.

Information is subject to unauthorized re-disclosure: I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and once re-disclosed, the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Records Department at (808) 974-6795.

Remuneration to Hilo Medical Center: _____ Applicable _____ Not Applicable
This authorization is for the use or disclosure of information by Hilo Medical Center for purposes of marketing that involves direct or indirect remuneration to Hilo Medical Center from another person or entity.

I have read all of the above, and I understand the full meaning of this authorization. I am signing this authorization voluntarily, and under no coercion.

Patient or Patient Representative's signature: _____ **Date:** _____

Name of Patient or Designated Patient Representative: _____

Relationship to Patient: ☐ Self ☐ Other: _____

Witness Signature: _____

- Identity of authorized signer verified by: ☐ State ID ☐ Driver's license ☐ Other_____
- Copy "designated patient representative" documentation obtained for permanent record (check one): ☐yes ☐no

ORIGINAL: HOSPITAL COPY: PATIENT/PATIENT REPRESENTATIVE
Revised Nov-2021

For Office Use Only:
Date of Request: _____ Received by: _____
☐Mail-USPS ☐Mail-FEDEX ☐Pick-up