

Hawaii HIPAA Authorization For Release Of Information

Use This Form To Allow The Release of Your Personal Health Information

Please keep a copy for your records

1. Member Name _____ Phone _____

Address _____ Member Number _____

2. List the personal health information you want to give out

- For example: "The claims information related to my hip surgery in January 2003," or "All my health information," or "All the records related to my heart problems"
- Use a separate form for release of psychotherapy notes
- You may also exclude some health information
 - For example: "all my health information except mental health records" or "all my medical records except x-ray films"

☐ Please check here if you authorize to give out information related to any of the following, should it be contained within your medical record:

- HIV, AIDS, or AIDS-related complex diagnosis or treatment
- alcohol or drug use, diagnosis, or treatment
- mental health counseling, diagnosis, or treatment

3. Name and address of the persons or organizations to give your personal health information

- For example: "My wife, Jane Doe" or "My grandson, John Doe"

Name: _____ Address: _____

4. Reason for the disclosure

- For example: "To answer questions about my claims" or "at the organization's request" or "for legal purposes"

5. Right to take back ("revoke")

- I may revoke this authorization at any time by giving written notice. I understand my revocation will NOT affect any disclosures that occurred before my written revocation and there may be other legal restrictions on my ability to revoke this authorization. For example, I understand that the revocation will not apply if this authorization was a condition for obtaining insurance coverage, when the law provides my insurer with the right to contest my policy or a claim under my policy.
- If I do not revoke it, this authorization will expire on the following date or event: _____
For example: "12/31/2004"
 - If a date or event is not specified, this authorization will expire **one year** from the date of signature below
- To revoke this authorization, I will write a letter including the following:
 - My name, address, and member number
 - The names of the persons or organizations I no longer wish to receive my personal health information
 - My signature
- I will mail or fax the letter to: _____

6. I authorize to give out the protected health information described above to the persons or organizations I named on this form. This authorization is voluntary. I understand that the releasee will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed by law. I understand my protected health information may be re-disclosed by the recipient(s) without my permission and may no longer be protected by law.

Signature _____

Date _____