WAIKIKI HEALTH

MEDICAL & DENTAL • PREVENTIVE CARE • SOCIAL SERVICES

AUTHORIZATION TO OBTAIN / RELEASE PROTECTED HEALTH INFORMATION

Note: all items with asterisk (*) must be completed for the authorization to be valid

Please complete and sign this form to authorize Waikiki Health to obtain or release your information that you specify for your stated purpose.

Please select clinic/site:

☐ Waikiki Health – Ohua
277 Ohua Avenue
Honolulu, Hawaii 96815
Phone: (808) 922-4787
Fax: (808 922-4950

☐ Waikiki Health – Makahiki
935 Makahiki Way
Honolulu, Hawaii 96826
Phone: (808) 922-4787
Fax: (808) 690-9308

☐ Waikiki Health – Care-A-Van
3020 Waialae Avenue
Honolulu, Hawaii 96816
Phone: (808) 791-9308
Fax: (808) 732-0735

☐ Waikiki Health – Next Step Shelter
Pier 1 – Forrest Avenue
Honolulu, Hawaii 96813
Phone: (808) 585-8800
Fax: (808) 690-9275

☐ Waikiki Health – Youth Outreach
415 Keoniana Street
Honolulu, Hawaii 96815
Phone: (808) 791-9366
Fax: (808) 942-9633

☐ Waikiki Health – PATH
845 22nd Avenue
Honolulu, Hawaii 96816
Phone: (808) 791-9390
Fax: (808) 734-4705

*Patient's Name: _____ Birth Date: _____

Address: _____

Phone: _____

I authorize the request/release of the below Protected Health Information.

To:
☐ WAIKIKI HEALTH
or
Name of business/individual:
_____
Address: _____
Phone: _____
Fax: _____

From:
☐ WAIKIKI HEALTH
or
Name of business/individual:
_____
Address: _____
Phone: _____
Fax: _____

Date(s) of Service: _____
_____ Entire Medical Record
_____ Medical Bills
_____ Other (Please specify):
_____
_____
_____

*Purposes of Use and/or Disclosure:
_____ Legal purpose
_____ To release information at my request
_____ Check only if WH requests the authorization for marketing purposes
_____ Check only if WH will be paid for providing health information for marketing purpose
_____ Other (Please specify):
_____
_____

I agree to the release of the following information related to the diagnosis, evaluation or treatment of the following conditions, should it be contained in my medical record:

_____ (initial) Sexually transmitted diseases
_____ (initial) Acquired Immune Deficiency Syndrome (AIDS), HIV, or AIDS-related complex
_____ (initial) Alcohol and/or drug abuse
_____ (initial) Psychiatric disorders/behavioral health/mental health
_____ (initial) Dental records and x-rays

(Unless I specifically agree, the above information will not be disclosed.)

*Unless otherwise revoked, this authorization will expire on the following date or event: _____. If a date or event is not specified, this authorization will expire one year from my date of signature below.

A reasonable fee may be charged by Waikiki Health for duplication of records. An estimate of those charges will be provided upon request, prior to duplication.

This authorization is voluntary. I understand that Waikiki Health will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed by law.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to Waikiki Health. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization and there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the 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.

I understand that the health information released under this authorization may be re-disclosed by the recipient without my permission and may no longer be protected under the HIPAA privacy regulations.

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use, request, and release of my protected health information, as described in this form.

*Requestor's Signature: _____ _____
Individual or legally authorized representative Date

To be completed only if the requestor is not the individual whose information is being released:

*Printed Name: _____

*Relationship to named individual: _____

*Date: _____

If the requestor is not the named individual, please provide a court order or other documentation evidencing the authority of the requestor to act on the named individual's behalf.