



KO'OLAULOA HEALTH CENTER

Patient Authorization to disclose Protected Health Information

Please Print Clearly: Patient LastName: _____ Patient First Name: _____
DOB: __/__/____ Contact Number: (____)-____-_____

AUTHORIZATION

I hereby Authorize Ko'olauloa Health Center to disclose the protected health information described below to the specified person also described below.

Description of the specified information to be released/discussed: (Please Initial all that apply)

Appointment date/time Lab/test results Imaging results

Medications Diagnosis Care plan

Summary of Medical record Billing

Drug/alcohol/substance abuse testing, history or treatment

Mental/Behavioral health/psychiatric testing, condition or treatment

HIV information STD testing or treatment

I Authorize the following person to receive the protected health information as described above:

Name: _____

Relationship: _____

Address: _____

Phone: _____

This authorization shall remain in effect from the date signed below until:

Expiration Date: _____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing
- This authorization is giving Ko'olaupoko Health Center the right to discuss my medical information with the person listed above
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA
- I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my protected health information pursuant to this authorization.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

Signature: _____ **Date:** _____

Relationship to Patient (If signed by an authorized representative of Patient):
