Ko'olau Women's Healthcare, Inc
642 Ulukahiki Street, #209
Kailua, HI 96734
Phone: 808-230-8500 FAX: 808-230-8501

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient (FIRST NAME, MIDDLE, LAST NAME) - Please print clearly	**Date of Birth**
I.I, _____ hereby voluntarily authorize the disclosure of health information from my health record.	

II. The information is to be DISCLOSED by:	**And is to be PROVIDED to:**
Name of Facility	**Dr. Bhattacharyya/Ko'olau Women's Healthcare, Inc**
PHONE	**PHONE 808-230-8500**
FAX	**FAX 808-230-8501**

III. The purpose or need for this disclosure is:

- ❑ Further Medical Care
- ❑ Personal Use
- ❑ Health Information Exchange (HIE)_____
- ❑ Other_____

- ❑ Attorney
- ❑ Insurance
- ❑ School
- ❑ Disability
- ❑ Research

IV. The information to be disclosed from my health record: (*check appropriate boxes***)**

❑ Only information related to *(specify):*

❑ Only the period of events from _____ to _____

If you would like any of the following sensitive information disclosed, check the applicable boxes below:

❑ Alcohol/Drug Abuse Treatment Referral	❑ HIV/AIDS-related Treatment
❑ Sexually Transmitted Diseases	❑ Mental Health (Other than Psychotherapy notes)

❑ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

(Specify new date) _____

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule and the Privacy Act of 1974.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (state relation)	DATE

PLEASE RETURN A COPY OF THIS AUTHORIZATION WITH THE RECORDS
THANK YOU FOR KINDLY FOR YOUR PROMPT RESPONSE