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Honolulu, HI 96814
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY #
PATIENT ADDRESS	CITY	ZIP CODE

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I understand that:

1. This authorization may include disclosure of information related to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except by psychotherapy notes, and CONFIDENTAL HIVE RELATED INFORMATION only if I place my initials on the appropriate line in item 9(A). In the event the health information described below includes any these types of information, and I initial the line of the box in item 9(A), I specifically authorize release of such information to the person(s) indicated in item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at any time by writing to the health care provided listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient if I have agreed to participate in a court ordered evaluation with the recipient, and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOE S NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THA THE INDIVIDAUL OR AGENCY SPECIFICED IN ITEM 9(B).

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(A) Specific information to be released:

_____ Medical records from (insert date)_____ to (insert date)_____

_____Entire medical record, including patient histories, office notes, test results, consults, and records Sent to you by other health care providers. Include: (indicate by initialing)

_____ALCOHOL/DRUG TREATMENT _____ MENTAL HEALTH INFORMATION _____ HIV-RELATED INFORMATION

9(B) AUTHORIZATION TO DISCUSS HEALTH INFORMATION

By initialing here_____ I authorize _____

To discuss my health information with_____

10. Reason for release of information:
_____ Custody Evaluation
_____ Mental Health Treatment
_____ Review of Prior Treatment

11. Date or event on which this authorization will expire:_____
Date

IF NO DATE IS SPECIFIED IT WILL EXPIRE 1 YR AFTER FROM DATE OF SIGNATURE

12. If not the patient or a minor, printed name of person signing form:

_____

Relationship to patient:_____

_____ _____

Signature of patient or representative authorized by law Date