

Ka Wai Ola Family Medical Clinic

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize Ka Wai Ola Family Medical Clinic to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Ka Wai Ola Family Medical Clinic to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on [enter date or defined event].

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Ka Wai Ola Family Medical Clinic. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Ka Wai Ola Family Medical Clinic
94-849 Lumiaina Street, Suite 207
Waipahu, Hawaii 96797

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Patient's Name Date

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.
