OAHU OB/GYN

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Accountability and Portability Act of 1996, HIPPA, requires that our office has your consent prior to our healthcare professional discussing your personal health with your family members or significant others.

*Can our Providers discuss your healthcare with any of your family members? YES / NO (please ***circle***)

*Name	Relationship	Telephone Number
________________________	________________________	________________________
________________________	________________________	________________________
________________________	________________________	________________________

*What kind of health information do you authorize Oahu OB/GYN to disclose to the designated person(s)?

____ All – at my Provider's discretion	_____ Tests ordered	_______Test Results
____ Date of Treatment	_____ Diagnosis	_______ Treatment Options
____ Treatment Plan	_____Medical History	___Other________________

This authorization will be in effect until such time you request its revision. You have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization.

You do not have to complete this authorization in order to receive treatment from Oahu OB/GYN.

Personal Health Information covered by this authorization will be disclosed only for the purpose of keeping your designated family members knowledgeable about your healthcare condition.

*_________________________________ *____/_____/_____

Signature Date

*_________________________________ *_____/_____/_____

Print Name **Date of Birth**