

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

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION	
Name of Patient (FIRST NAME, MIDDLE, LAST NAME) - Please print clearly	Date of Birth
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: <input type="checkbox"/> Further Medical Care <input type="checkbox"/> Personal Use <input type="checkbox"/> Health Information Exchange (HIE) _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Attorney <input type="checkbox"/> Insurance <input type="checkbox"/> School <input type="checkbox"/> Disability <input type="checkbox"/> Research
---	--

IV. The information to be disclosed from my health record: (check appropriate boxes)	
<input type="checkbox"/> Only information related to (specify): _____	
<input type="checkbox"/> Only the period of events from _____ to _____	
If you would like any of the following sensitive information disclosed, check the applicable boxes below:	
<input type="checkbox"/> Alcohol/Drug Abuse Treatment Referral	<input type="checkbox"/> HIV/AIDS-related Treatment
<input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> Mental Health (Other than Psychotherapy notes)
<input type="checkbox"/> 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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or <i>expiration event</i> is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years. <div style="text-align: center;">(Specify new date) _____</div>	
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