Kīpuka o ke Ola

Physical Address: 64-1035 Māmalahoa Hwy, Suite F Kamuela, HI 96743
Mailing Address; PO Box 818, Kamuela, HI 96743
Office: (808) 885-5900 FAX: (808) 885-6900

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. I hereby authorize all Kīpuka o ke Ola Providers to release/receive information to/from:

Individual/Agency: _____

Address: _____ Phone and/or FAX: _____

2. It is very important to your care that we can access necessary health records from NHCH/Queen's known as "CareLink". This access allows us for paperless transmittal of health records if you have previously been a patient at NHCH/Queen's. If you DO NOT want us to have access, please OPT OUT by initialing below.

I would like to OPT OUT of having KOKO access my CareLink records: _____

3. Pertaining to the care of:

Last Name: _____ First Name: _____

DOB: _____ and/or Social Security #: _____-_____-_____

4. For the Purpose of:

_____

5. Description of information: Disclosure is authorized for any and all information about medical, personal or mental health history, mental and physical condition, including HIV infection, AIDS, or ARC, drug or alcohol use, and other personal information.

_____

6. Fees A reasonable fee will be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

7. Duration of validity: This authorization is valid for six (6) months from the date of signing unless revoked in writing by the undersigned prior to six (6) months. I understand that the revocation will not apply to any action taken in reliance on this authorization.

8**. Re-disclosure**:The information used and/or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

9. Signature: I have read and agree to the disclosure of my protected health information to the above stated individual/ agency.

Date _____

Telephone _____ Signature _____