UNIVERSITY OF HAWAII
[UH COVERED COMPONENT]

Authorization for Use or Disclosure of Protected Health Information

I authorize _____ [Insert name of **[UH COVERED COMPONENT]**, individual, etc.] to disclose the following information from the health records of:

Name (Please print first and last name)	Date of Birth (MM/DD/YY)
Phone Number	
Street Address	
City / State / Zip	Email Address

I authorize the following persons (or class of persons) to receive my Protected Health Information (PHI):

Name (Please print)	
Phone Number	
Street Address	
City / State / Zip	Email Address

INFORMATION TO BE RELEASED

ENTIRE RECORD **including** the following (initial as applicable; if not initialed, the information described cannot be released):

____ (initial) HIV / AIDS
____ (initial) Sexually Transmitted Disease
____ (initial) Other Communicable Diseases
____ (initial) Genetic Testing
____ (initial) Developmental/Behavioral Health/Psychiatric Care
____ (initial) Treatment of Alcohol and/or Drug Abuse

PURPOSE FOR DISCLOSURE (check as applicable)

□ Treatment □ Research □ Medical Hardship Waivers
□ Legal Investigation or Action □ Insurance Eligibility/Benefits
□ Other (Please specify)

EXPIRATION DATE:

*Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the University of Hawaii System HIPAA Privacy Officer (at **[Name and Address of System HIPAA PRIVACY OFFICER]**) and [UH COVERED COMPONENT] Unit HIPAA Coordinator (at **[Name and Address of UNIT HIPAA COORDINATOR for the UH COVERED COMPONENT]**). Unless revoked, this authorization will expire on the following date or event:*

*NOTE: If this authorization is for a use or disclosure of PHI for research, “end of research study,” “non,” or similar language is sufficient.

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this authorization.

I have read and understood the terms of this authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page 1) to use or disclose my health information in the manner described above.

_____
Signature

_____ _____
Print Name Date

Description of authority to sign if personal/legal representative:

_____