KŪ ALOHA OLA MAU

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900 Leilani Street	**P.O. Box 2300**
Hilo, Hawaii 96720	**Pahoa, HI. 96778**
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AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

Section A: **Use or Disclosure of Health Information**
By signing this form, I authorize the disclosure/acquirement of my protected health information maintained by:

Name: **Kū Aloha Ola Mau**

Address: **1130 N. Nimitz Hwy C302, Honolulu, HI 96817** Phone: **(808) 538-0704**

My health information may be disclosed to:

Name: ____

Address: ____Phone: ___________________

Section B: **Scope and Use of Disclosure**
Information that may be disclosed based on this authorization is as follows (Check only those applicable to this disclosure.)

☐Attendance ☐Drug Screen Results ☐Discharge Summary ☐Psychiatric Evaluation
☐ISP ☐Physician Orders ☐Treatment Summary ☐Lab Reports
☐Medication Dose ☐UA Results ☐Diagnosis ☐Assessment: _________
☐Verification ☐Dose hx ☐Pharmacy ______________ ☐Transportation
☐Physical Examination & Nursing Assessment ☐Presence on site
☐Appointment information/scheduling ☐Confirmation of program enrollment
☐Other ______________________________________

Section C: **For the purpose of**
☐Coordination of treatment ☐To meet the requirements of the court ☐Probation/Parole
☐Continuity of Care ☐Other _______________________ ☐Family Involvement

Section D: **Forms of information** (Initial all forms in which consent applies.)
Verbal ________________ Written _______________ Electronic/Facsimile ____________

Section E: **Other Important Information**
This consent may be revoked at any time, upon notice of the person who has signed below, except when action has already been taken. Without revocation, this consent will expire **one year** from date of signature.

The types of medical information above cannot be released without my specific consent and knowledge. I hereby release Kū Aloha Ola Mau and its staff from all liability and all claims of any nature pertaining to the disclosure of information of any professional opinions, findings, or recommendations contained in these records.

I acknowledge that I have the option to have received a copy of this authorization. ______________
(initial)

Patient Name: ____Date of Birth: ___________________________

Signature: ____Date: ________________________________

Signature of Witness: __________________________________Relationship to patient: ____________________

Redisclosure is prohibited

This information has been disclosed to you from records protected by Federal (42 CFR part 2), Federal Health Insurance Portability and Accountability Act (HIPAA 45 CFR, parts 160 & 164), and State (HRS 325-101) confidentiality rules. The Federal rules and State law prohibit further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2, HIPPA, and HRS 325-101. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Revised: April 2007
Rev: 3/2011 MQ