

# KŪ ALOHA OLA MAU

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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**

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.)

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Attendance                                | <input type="checkbox"/> Drug Screen Results | <input type="checkbox"/> Discharge Summary                  | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> ISP                                       | <input type="checkbox"/> Physician Orders    | <input type="checkbox"/> Treatment Summary                  | <input type="checkbox"/> Lab Reports            |
| <input type="checkbox"/> Medication Dose                           | <input type="checkbox"/> UA Results          | <input type="checkbox"/> Diagnosis                          | <input type="checkbox"/> Assessment: _____      |
| <input type="checkbox"/> Verification                              | <input type="checkbox"/> Dose hx             | <input type="checkbox"/> Pharmacy _____                     | <input type="checkbox"/> Transportation         |
| <input type="checkbox"/> Physical Examination & Nursing Assessment |  | <input type="checkbox"/> Presence on site                   |   |
| <input type="checkbox"/> Appointment information/scheduling        |  | <input type="checkbox"/> Confirmation of program enrollment |   |
| <input type="checkbox"/> Other _____                               |  |   |   |

### Section C: For the purpose of

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Coordination of treatment | <input type="checkbox"/> To meet the requirements of the court | <input type="checkbox"/> Probation/Parole   |
| <input type="checkbox"/> Continuity of Care        | <input type="checkbox"/> Other _____                           | <input type="checkbox"/> 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: \_\_\_\_\_

#### Redislosure 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, HIPAA, and HRS 325-101. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Rev: 3/2023