REHAB Hospital of the Pacific | REHAB's Physicians Clinic | REHAB at Nuuanu | REHAB at Aiea | REHAB at Hilo

REHAB Hospital of the Pacific
Dedicated to Rebuilding Lives

Health Information Management Department
226 North Kuakini Street, Honolulu, HI 96817
my.records@rehabhospital.org
Phone: (808) 566-3888 | Fax: (808) 535-2007 & (808) 566-3744

AUTHORIZATION TO USE/DISCLOSE PATIENT PROTECTED HEALTH INFORMATION

To prevent delays, all items marked with an " " **must be completed** for a valid authorization*

***Patient Full Name:**		**Other Known Names:**	***Birthdate (MM/DD/YY)**
***Phone:**	***Email:**	**Last 4 digits of SSN:**	**MRN, if known:**
***Home Street Address** ***City, State, Zip Code:**		**Mailing Street Address (if different from home address):** **City, State, Zip Code:**	

*I hereby authorize REHAB Hospital of the Pacific to use or disclose the above individual's protected health information to:

☐ Self/Patient

☐ Name of Institution/Provider/Other Person: _____

Street Address:	**Delivery/Format:** ☐ Fax (electronic): _____ ☐ Secure Email (electronic): _____ ☐ Mail (paper, fees may apply)
City, State, Zip Code:	
Phone:	

***INFORMATION TO BE DISCLOSED:**

Date(s) of Service: _____

☐ Medical record summaries only (i.e. H&P, imaging, labs, discharge summaries, team evaluations)

☐ All medical records (may incur prepayment if not electronic)

☐ Billing (i.e. what has been billed, what has been received as payment)

☐ Other (please specify): _____

I agree to the disclosure of the following information if it is contained in my record. If not initialed, this information will not be disclosed.

_____**(initial) Psychotherapy notes**

_____**(initial) Substance abuse treatment/management**

_____**(initial) AIDS or HIV diagnosis or treatment**

_____**(initial) Genetic testing information**

_____**(initial) Reproductive health information**

***PURPOSE OF DISCLOSURE:**

☐ For personal records/at request of patient ☐ For a care provider ☐ Other (please specify):_____

REVOCATION: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department, REHAB Hospital of the Pacific, 226 N Kuakini Street, Honolulu, HI 96817, 808-535-2007. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply when the authorization was obtained as a condition for obtaining insurance coverage.

EXPIRATION: The authorization will expire (specify a date or event) _____. If I fail to specify an expiration date or event, this authorization will expire 180 days from the date it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

SIGNATURE: I understand authorizing the use or disclosure of information identified above is voluntary. I understand I do not need to sign this form for healthcare treatment.

_____

***Signature, handwritten, of patient or legal authorized representative†** **Relationship to patient, if not patient** ***Date**

† must submit legal documentation of representative status

_____

Signature of witness **Date**