PRIMARY CARE PARTNERS OF HAWAII
1441 Kapiolani Blvd. Suite 1525
Honolulu HI. 96814
Phone: (808) 489-9390

AUTHORIZATION TO USE/DISCLOSE PATIENT HEALTH INFORMATION

I authorize(Previous Physician)__________________________________*to release/obtain/inspect protected health information of;* Patient Name____________________________D.O.B.__________Phone ____________

***********LARGE RECORDS MAY BE FAXED TO 808-489-9390*************

To: (Primary Care Partners of Hawaii LLC) Dr. Julie Y. Asari, M.D.

1441 Kapiolani Blvd., Suite 1525, Honolulu HI 96814.

Information to be disclosed/obtained

Date(s) of Service ________________

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consults
- ☐ Operative Reports
- ☐ Other
- ☐ ER report
- ☐ Laboratory Results
- ☐ X-Ray/Imaging Reports
- ☐ Entire Record

Please Specify____________________________

Purposes for Use and/or Disclosure

At the request of the individual
Legal Purposes
Insurance
Physician follow-up
Other________________________
____

Pt's initials) _______ **ALCOHOL and/or DRUG ABUSE TREATMENT RECORDS**
(*Pt's initials*) _______ **MENTAL HEALTH TREATMENT RECORDS**
(*Pt's initials*) _______ **SEXUALLY TRANSMITTED DISEASES INCLUDINGS AIDS & HIV TESTING RECORDS.**

***Right to revoke authorization*: 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 Primary Care Partners of Hawaii, LLC. I understand that the revocation will not apply to information that has already been released or used in response to this authorization. I understand that revocation will not apply to my insurance company if this authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the tight to contest a claim under my policy or my policy itself.**

***Expiration:* Unless sooner revoked, this authorization will expire on the following date, event, or condition of ________________.**

If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

***Voluntary Disclosure*, not a condition to treatment: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. Signing this authorization is not a condition to treatment. I cannot be denied treatment even if I refuse to sign this authorization.**

Information is subject to unauthorized re-disclosure: I understand that any disclosure of information carries with it then potential for an unauthorized re-disclosure and once re-disclosed, the information may not be protected by federal confidentiality rules.

***Remuneration to Primary Care Partners*: ________Applicable _________Not Applicable. This authorization is for the use or disclosure of information by Primary Care Partners of Hawaii LLC for purposes of marketing that involves direct or indirect remuneration to Primary Care Partners of Hawaii LLC.**

I HAVE READ ALL OF THE ABOVE, AND I UNDERSTAND THE FULL MEANING OF THIS AUTHORIZATION. I AM SIGNING THIS AUTHORIZATION VOLUNTARILY, AND UNDER NO COERCION.

Patient or Patient's Rep's Signature; ______________________________________Date: _____________

Name of Patient or Designated Patient Representative: ____________________________________

Relationship to Patient: ______________________________________

Witness Signature: ____Date: _____________

- *Identity of authorized signer verified by: State ID ___ Driver's License ___ Other ____________________*
- *Copy "designated patient representative" documentation for permanent record (check one): ____yes ____ no______*