BIG ISLAND Healthcare
ECARE Hawaii LLC

Authorization for Release of Medical Information

Patient Name:	**Date of Birth:**
Address:	**Phone #:**
City/State/Zip:	**Email:**

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize healthcare provider to release my personal health information to the recipient(s) that I have identified below.

Previous Healthcare Provider: Big Island Healthcare	**Address/City/State/Zip:**
Phone: 808-885-3628	**Fax:** 808-969-3852

Recipient: I authorize my healthcare information to be released to the following recipient(s):

Healthcare Provider:		**Address/City/State/Zip:**
Phone:		**Fax:**
Please specify media type	**Electronic Records:** ☐ Secure Email: _____ ☐ Fax: _____ (number where records should be faxed)	
	Paper Records: ☐ Mail – In-person pick-up (BIHC ONLY) ☐ Ponahawai ☐ Kilauea	

I understand and acknowledge that certain information which may be contained in the medical record requires specific authorization for disclosure, and except as otherwise provided by law, such information may not be disclosed with my specific consent.
Additionally, I have the right to refuse disclosure and prevent any other person from disclosing sensitive information. Such information could include: (1) treatment for mental or emotional conditions, (2) alcohol/drug abuse, and/or (3) HIV testing and/or test results.

☐ **DO NOT release my sensitive information**

Purpose for release: ☐ Self/Personal ☐ Continuing Care ☐ Insurance ☐ Legal ☐ Other(specify): _____

This authorization is for the listed date(s) of treatment: From: _____ **To:** _____

Information to be released/disclosed (check all that apply):

☐ Abstract (includes H&P, Operative Report, Consult Reports, Test Reports, Discharge Summary)

☐ Physician Office Note
☐ Emergency Room Report
☐ Laboratory Reports
☐ History & Physical
☐ Operative Report
☐ Radiology Reports
☐ Consultation Report
☐ Pathology Report
☐ Radiology Imaging CD
☐ Discharge Summary
☐ Cardiology Report
☐ Cardiology Imaging CD

☐ Other (please specify): _____

Redisclosure: I understand that my healthcare provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I do hereby agree to release, indemnify, and hold harmless, Big Island Healthcare, its officers, directors, employees, agents and members of its medical staff, from and against any claims against or liability incurred by it at any time, arising out of or in connection with the disclosure of medical information authorized by me pursuant to this consent. Signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protection of federal privacy laws.

This consent may be revoked at any time by notifying the Privacy Officer, except to the extent that the receiving facility has already taken action in reliance on it. This consent and authorization shall automatically expire six (6) months from the date of the consent, unless revoked by the patient or patient's authorized representative prior to that time.

_____ _____

Signature of Patient(s) or Parent/Guardian of Patient(s) Date

_____ _____

Legal Representative Relationship