BIG ISLAND Healthcare
ECARE Hawaii LLC

633 Ponahawai St., Ste 103 & 409 Kilauea Ave., Hilo, HI 96720
Phone: 808-885-DOCS (808-885-3627)
Fax: 808-969-3852

LAST NAME	SUFFIX	FIRST NAME	MI	PREVIOUS NAMES
PATIENT'S **MAILING** ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)				HOME PHONE
PATIENT'S **PHYSICAL** ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)				CELL PHONE
PREFERRED CONTACT ☐ CALL ☐TEXT ☐ EMAIL	EMAIL			WORK PHONE
DATE OF BIRTH	SEX ☐ M ☐F ☐OTHER	MARITAL STATUS ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed		PREFFERED LAB
EMERGENCY CONTACT NAME		EMERGENCY CONTACT RELATION		PREFERRED PHARMACY
EMERGENCY CONTACT ADDRESS (if different from your address)				EMERGENCY CONTACT PHONE #
PREVIOUS PRIMARY CARE DOCTOR		LAST APPT		PHONE NUMBER

If patient is a MINOR, please complete the following:

PARENT/GUARDIAN'S NAME	RELATIONSHIP TO PT	MARITAL STATUS ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	
HOME PHONE	WORK PHONE	CELL PHONE	CHILD'S SCHOOL
PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD		RELATIONSHIP TO PATIENT	

INSURANCE INFORMATION

☐ PRIVATE INSURANCE ☐ WORKERS' COMPENSATION ☐ NO-FAULT ☐ TPL

PRIMARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐M ☐F ☐DTR	BIRTHDATE
	EMPLOYER		EFF DATE
Phone: Fax:	MEMBERSHIP# / POLICY# / CLAIM #	GROUP #	COVG CODE
SECONDARY INSURANCE NAME & ADDRESS	SUBSCRIBER NAME	SEX ☐M ☐F ☐DTR	BIRTHDATE
	EMPLOYER		EFF DATE
Phone: Fax:	MEMBERSHIP# / POLICY# / CLAIM #	GROUP #	COVG CODE

OTHER INFORMATION

ARE YOU A SMOKER? ☐ Y ☐ N	ARE YOU HISPANIC? ☐ Y ☐ N	RACE ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Black or African American ☐ White ☐ Other

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and ASSIGNMENT OF INSURANCE BENEFITS:

Do you authorize the release of medical information about you to anyone such as your spouse, children, etc.?
☐ Y ☐ N **IF YES,** TO WHOM? RELATIONSHIP

I authorize and consent to diagnostic, medical, and surgical treatments rendered to me, my child or individual under my guardianship when provided under the instruction of my attending physician or nurse practitioner.

In case of a minor child or person under guardianship, this authorization will be valid even when I am not physically present during the treatment. I understand that this authorization is given in advance of any specific diagnosis, treatment, or care being required but is given to provide authority and power to render care when the practicitioner, in the exercise of his/her best judgement, may deem advisable.

I understand that every effort will be made to use insurance coverage when applicable, but that I am ultimately responsible for all charges incurred at this office and whenever I am referred elsewhere for physician, laboratory or diagnostic services.

I authorize this office to disclose health information about me for treatment, payment, and operations. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me.

I authorize Big Island Healthcare, or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan, to Big Island Healthcare.

_____ _____ _____
Patient/Parent/Guardian Signature Relationship to Patient Date

Rev 07/23

FOR OFFICE USE ONLY

_____ _____
UPDATED NEW

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:	**Address/City/State/Zip:**
Phone:	**Fax:**

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

Healthcare Provider: Big Island Healthcare	**Address/City/State/Zip:**
Phone: 808-885-3627	**Fax:** 808-969-3852

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

BIG ISLAND Healthcare
ECARE Hawaii LLC

PATIENT CONSENT FOR CARE AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I do hereby give consent to Big Island Healthcare and associates to provide medical evaluation and treatment for myself or my minor child.

I hereby give my consent for Big Island Healthcare to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO), (Big Island Healthcare Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I hereby give consent for Big Island Healthcare to send me Text/SMS Messages for Campaigns, Surveys, and other Healthcare Communications. By providing an email and/or cell phone number, I authorize to receive email and/or text messages from Big Island Healthcare for surveys, health campaigns, and general health reminders/information.

I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/campaigns/health information unless I request a change in writing.

I authorize and consent to diagnostic, medical, and surgical treatments rendered to me, my child or individual under my guardianship when provided under the instruction of my attending physician or nurse practitioner.

We are a teaching facility and medical, nursing, and physician assistant students are frequently part of the patient care team here at Big Island Healthcare. Under the supervision of the provider, I consent to having a medical student to participate in my medical care.

In case of a minor child or person under guardianship, this authorization will be valid even when I am not physically present during the treatment. I understand that this authorization is given in advance of any specific diagnosis, treatment, or care being required but is given to provide authority and power to render care when the practitioner, in the exercise of his/her best judgement, may deem advisable.

I understand that every effort will be made to use insurance coverage when applicable, but that I am ultimately responsible for all charges incurred at this office and whenever I am referred elsewhere for physician, laboratory or diagnostic services.

I authorize Big Island Healthcare to release any medical or other information necessary to process insurance claims. This includes the release of medical records to my insurance company or other entities as required to obtain payment for services provided. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on this authorization.

I authorize Big Island Healthcare to submit claims to my insurance carrier for any services provided to me. I direct my insurance company to make payments directly to Big Island Healthcare for the covered services rendered. I understand that I am financially responsible for any amounts not covered by my insurance plan, including co-pays, deductibles, and any services deemed non-

covered or not medically necessary by my insurance carrier.

I authorize this office to disclose health information about me for treatment, payment, and operations. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me.

I authorize Big Island Healthcare, or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan, to Big Island Healthcare.

I have the right to review the Notice of Privacy Practices prior to signing this reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Big Island Healthcare Privacy Officer at 670 Ponahawai Street Suite 117 Hilo, Hawaii 96720.

With this consent, Big Island Healthcare may call my home or other alternative location and leave a message or voice mail or in person in reference to any items that assist the practice in carrying our TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Big Island Healthcare may mail to my house or other alternative location any items that assist the practice in carrying our TPO, such as appointment reminder cards and patient statements.

I have the right to request that Big Island Healthcare restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by its agreement.

By signing this form, I am consenting to Big Island Healthcare use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Big Island Healthcare, may decline to provide treatment to me.

Effective Date of This Notice: 10/01/2020

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentially of health information that identifies you. We also are required by law to provide you with this notice of legal duties and the privacy practices that we maintain in our practice that we maintain in our practice concerning you IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we may create or maintain in the future. Our practice will post a copy of your current Notice of our offices in a visible location at all ties, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT: Privacy Officer, Telephone (808)885-3627
670 Ponahawai Street Suite 117 Hilo, Hawaii 96720.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI)IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IHII in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription to you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IHII to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly

for services and items. We may disclose your IHII to other health care providers and entities to assist in their billing and collection efforts.
3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assist in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to the child's medical information.
8. Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:
1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purposes of:
- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury, or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding the risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil right laws and the health care system in general.
3. Lawsuits and Similar Processing. Our practice may use and disclose your IIHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request , subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena, or similar legal process
- To identify/locate a suspect, material witness, fugitive, or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description identity or location of the perpetrator)

5. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye, or tissue procurement or transplantations, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
7. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
8. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. WE also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
9. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IHII
You have the following rights regarding the IIHI that we maintain about you:
1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer at (808)885-3627 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do no need to give a reason for your request.
2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure or your IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We ARE NOT required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Privacy Officer at (808)885-3627. Your request must describe in a clear and concise fashion:
(a) the information you wish restricted

(b) whether you are requesting to limit out practice's use, disclosure, or both; and

(c) to whom you want the limits to apply

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer at (808)885-3627 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at (808)885-3627. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that create the information is not available to amend the information.
5. Accounting or Disclosures. All our patients have the right to request an "accounting of

disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment, or non-operation purposes. Use of your IIHI as part of the routine patient care in our practices is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance
claim. To obtain an accounting of disclosures, you must submit your request in writing to the Privacy Office at (808)885-3627. All requests for an "account of disclosures" must state a time period, which may not be longer than six (6) years for the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer at (808)885-3627.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint without practice or with the Secretary of the Department of Health and Human Services. To file a complaint without practice, contact the Privacy Officer at (808)885-3627. All complaints must be submitted in writing. You WILL NOT be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable
law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer at (808)885-3627.

Patient/Parent/Guardian Consent	Relationship to Patient	Date