ST. FRANCIS HEALTHCARE SYSTEM OF HAWAII

Print Form

Reset Form

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____ Telephone #: _____

1. By signing this Authorization form, I give permission to:

   ☐ St. Francis Hospice _____

   ☐ St. Francis Home Care Services _____

   ☐ Other - Name: _____

   Address: _____

2. To disclose my health information to:

   Name: _____ Telephone: _____

   Address: _____

3. For the purpose of: _____

4. Type of record(s) to be disclosed:

   ☐ Discharge summary ☐ Pathology reports ☐ Complete medical record

   ☐ Medical history and physical ☐ Emergency room records ☐ Billing records

   ☐ Consultation reports ☐ X-ray and imaging reports ☐ Other: _____

   ☐ Operative reports ☐ X-ray films _____

5. Dates of Treatment: From: _____ To: _____

6. I specifically authorize disclosure of the following restricted health information:

   _____Initials Records containing information about HIV Infection, AIDS or AIDS Related Complex (ARC)

   _____Initials Records containing information about diagnosis or treatment of a mental illness

   _____Initials Records containing information about treatment for alcohol and/or drug abuse

7. I understand that I do not have to sign this Authorization form. If I do not sign this form, my decision will not affect my treatment, payment for my treatment, my continued enrollment in a health plan, or my continued eligibility for health plan benefits, except as allowed by law.

8. I understand that some of the persons who receive my health information, based upon this Authorization, may not be required to follow Federal privacy laws. Therefore, my health information may no longer be protected by law. There is a chance that my health information may be shared with others without my permission.

9. I have the right to revoke (take back) this Authorization at any time. To revoke this Authorization, I must write to the Health Information Management department. I understand that the revocation will not apply to actions St. Francis Healthcare System of Hawaii or its Subsidiary Corporations have already taken based upon this Authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurance company with the right to contest a claim under my policy.

10. Unless revoked, this Authorization will expire on the following date or event: _____
    If an expiration date or event is not specified, this Authorization will expire in one year.

_____ _____

Signature of Patient or Patient's Personal Representative Date

_____ _____

Print Name of Personal Representative Witness (if patient signs with a "mark")

Authority of Personal Representative: ☐ Durable Power of Attorney for Health Care Decisions ☐ Parent of minor

☐ Guardian ☐ Surrogate ☐ Executor ☐ Other: _____

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