REHAB Hospital of the Pacific
Dedicated to Rebuilding Lives

AUTHORIZATION TO USE/DISCLOSE PATIENT PROTECTED HEALTH INFORMATION

PATIENT:	AKA:	DOB:
BEST PHONE NUMBER:	EMAIL:	LAST 4 OF SSN:

STREET ADDRESS CITY, STATE ZIP CODE:	MAIL TO ADDRESS (if different than street address) CITY, STATE ZIP CODE:

1. **INFORMATION TO BE DISCLOSED: Specify information to be released.**

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

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

   ☐ Complete Medical Record **(may incur a prepayment if not electronic)**

   If the information listed below is requested there may be additional laws that apply to release. The following information will **not** be released if **not** initialed. This means that the information will be released if initialed.

   _____ Psychology/Psychiatry records
   _____ Substance abuse treatment/management
   _____ AIDS or HIV diagnosis or treatment
   _____ Genetic testing information

   Date requested: From _____ **To** _____

   Media:
   ☐ Electronic (free) ☐ Paper (fees apply)

   Delivery:
   ☐ Secure email ☐ Mail (for paper only)

2. **PURPOSE OF DISCLOSURE:**
   ☐ My personal records / at request of patient ☐ For a Care Provider ☐ Other: _____

3. **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.

4. **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 on which it was signed.

5. **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.

6. **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 of patient or authorized representative (must provide legal documentation of representative status)		**Date**
Signature of witness		**Date**

Please return this form to a nurse or technician caring for you; by email to myrecords@rehabhospital.org or fax to (808) 535−2007. Please see https://www.rehabhospital.org/frequently−asked−questions#health_information OR call (808) 566−3888 if you have any questions.