HAWAII PACIFIC NEUROSCIENCE, LLC

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize * _____ to release/obtain the protected health information of

*Patient Name: _____ Birthdate: _____

Address: _____ Phone No.: _____

To: *Name or Institution: _____

Address: _____ City, State, Zip: _____

Phone No: _____ Fax No.: _____

*Information to be disclosed:		* Purposes for Use and/or Disclosure:
Date(s) of Service: _____		
□ Progress Notes	□ Imaging Report(s)	□ At the request of the individual
□ EMG Report(s)	□ Carotid Duplex Report(s)	□ Legal Purposes
□ EEG Report(s)	□ Laboratory Results	□ Insurance
□ Entire Record		□ Physician follow-up
□ Other:		□ Other: _____
Please specify: _____		

_____ **(Initial) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services. (If I do not specifically agree, this information will not be disclosed):**

***Unless otherwise revoked, this authorization will expire on the following date or event: _____. If a date or event is not specified, this authorization will expire one year from my date of signature below.**

This authorization is voluntary. I understand that I can refuse to sign this authorization and Hawaii Pacific Neuroscience, LLC (HPN) will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: (i) research-related treatment; or (ii) health care provided solely for disclosure to a third party or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

I understand that I may revoke this authorization at any time by notifying HPN, in writing, of my revocation. I understand that the revocation will not apply to any information that already was released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I hereby release Hawaii Pacific Neuroscience, LLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Hawaii Pacific Neuroscience, LLC.

*Signature: _____ *_____
Patient or Personal Representative — Print Name

*Relationship: _____ *_____
(Relationship to Patient) **Complete only if requestor is not patient* — Date

* Items that MUST be completed for authorization to be valid.