State of Hawaii Department of Health

Authorization for Use or Disclosure of Protected Health Information (PHI)

Name of Individual/Organization Disclosing Protected Health Information	
Name: State of Hawaii Department of Health Adult Mental Health Division	Address: P.O. Box 3378 Honolulu, Hawaii 96801-3378
Name of Individual/Organization That Will Receive the Individual's Protected Health Information	
Name:	Address:
Client/Patient Whose Protected Health Information is Being Requested	
First Name:	Last Name:
Address:	Birth Date (if known):

I Authorize that the Following Protected Health Information be Used/Disclosed: (Be specific. Identify limits, as appropriate. Initial in the space provided if your authorization includes the use/disclosure of specially protected health information)	
X____Mental Health X____Substance Abuse Treatment X____HIV/AIDS	
The Protected Health Information is Being Used or Disclosed for the Following Purposes (*At the request of the Individual* is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose.):	
Authorization Duration (This authorization will be in force and effect until the date *or* event specified below. At that time, this authorization to use or disclose this protected health information expires)	
Authorization Expiration Date:	Expiration Event That Relates to the Individual or the Purpose of the Use or Disclosure

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA, 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or redisclosed without my authorization.

The Entity or Person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

☐ The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Department from a Third Party.

Individual or Personal Representative Signature:	Date:
Print Name of Individual or Personal Representative	Description of Personal Representative's Authority

[Attachment D to AMHD Directive 2006-14]
[January 1, 2007]