## HALEIWA FAMILY HEALTH CENTER PATIENT AUTHORIZATION FORM

I understand that (please read):

1. This authorization is based on my own need and HFHC (Haleiwa Family Health Center) does not condition treatment or payment on receiving this authorization.
2. I may revoke this authorization at any time by giving HFHC five business days' written notice. If I revoke this authorization, it will not affect any action HFHC took prior to receiving my written notice.
3. Once my confidential patient information is disclosed to the person or organization I specify below, the information in their possession may no longer be protected by privacy laws.
4. I may request a copy of this signed form.

### PART A: PATIENT INFORMATION - my own information (all data fields must be completed)

| First Name | MI | Last Name |
|---|---|---|
| | | |

| Birth Date (mm/dd/yyyy) | Contact Phone Number |
|---|---|
| | |

| Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

### PART B: INCLUSION OF MINOR CHILDREN - If Applicable

If you wish for your minor children to be included in this authorization, please list their names here:

### PART C: SCOPE OF AUTHORIZATION, PURPOSE, AND EXPIRATION

| Options (check one) | Description | Purpose (check one) | Expiration (check one) |
|---|---|---|---|
| ☐ Unrestricted | I authorize the third party named in Part D below to act on my behalf regarding my PHI. This third party will have the same ability that I have to take any and all actions with regard to my PHI. Examples: obtaining my confidential patient information; updating my address; etc. | ☐ This authorization is at my request<br>☐ For the following purpose (please describe): | ☐ When I notify HFHC in writing of my termination of this authorization<br>☐ Through Date ____/____/____<br>☐ Until this event (please describe): |
| ☐ Restricted | I authorize the third party named in Part D below only to obtain my confidential patient information held by HFHC. The information I permit to be disclosed is (check those that apply):<br>☐ ALL my confidential patient information<br>☐ ONLY specific information (please describe): | | |
| ☐ Other | I authorize the third party named in Part D below to (please describe): | | |

### PART D: THIRD PARTY INFORMATION, I authorize the following person(s) or organization(s):

| Name of Person or Organization | Address | Contact Phone Number(s) | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

I, (print your name)_____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am authorizing HFHC to release my information as described above.

Patient/Authorized Signature*:_____ Date:_____

*If you are signing on behalf of the member, please provide a copy of verification of your legal right (e.g. power of attorney documentation) to make this authorization.

| | Date Received: | Received By: |
|---|---|---|
| | Date Revoked: | Received By: |