KAHALA PEDIATRICS, LLC
3150 Monsarrat Ave., Suite 200
Honolulu, Hawaii 96815
Phone (808) 735-5541
Fax: 808-734-5923

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION DATE _____

I authorize **Kahala Pediatrics, LLC and/or its designee(s)** to **use** and **disclose** my medical for the purposes of Treatment, Payment and Health Care Operations.

Treatment includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice on site and by telephone as the on-call physician.

Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

Health Care Operations include the necessary administrative and business functions of our office.

I further authorize **Kahala Pediatrics, LLC and/or its designee(s)** to use and disclose the following specific health and medical information for the below listed purpose(s):

Specific health and medical information consisting of:

__History & Physical
__Consults
__Laboratory Results
__X-Ray/Imaging Reports
✓The Entire Record
__Other_____

*Paper records only. Please mail if more than 10 pages.

For the specific purpose of:

__At the request of the undersigned individual
__Legal Purpose
__Insurance
✓Physician follow-up

✓Transfer of records x from or __to :_____ Telephone #
Address:

I agree to the release of the following information should it be contained in my health and medical information: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services.

If **Kahala Pediatrics, LLC and/or its designee(s)** is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

1) We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2) You may inspect a copy of the protected health information to be used or disclosed;
3) You may refuse to sign this Authorization; and
4) We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review the Kahala Pediatrics, LLC Notice of Privacy Practices for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have reviewed a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your visit to us after the effective date of the then current Notice for your review while at the office. We will also provide you with a copy of the Notice upon your written request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that the 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 Kahala Pediatrics, LLC and/or its designee(s), from all liability and all claims of any nature whatsoever pertaining to discloser of information, or of any professional opinions, recommendations or findings as contained in the information released to or by Kahala Pediatrics, LLC and /or its designee(s).

I understand that I have the right to revoke this Consent provided that I do so <u>in writing</u>, except to the extent that* Kahala Pediatrics, LLC and/or its designee(s) *has already used or disclosed the information in reliance on this Consent.

Date:_____

_____ _____

Name of Patient | Patient Date of Birth

_____ _____

Signature of Person Authorized by Law | Printed Name

xxx-xx-__ __ __ __

Social Security Number of Person Signing (last four digits)