



HAWAII CENTER
for PSYCHOLOGY
FINDING YOUR BALANCE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Hawaii Center for Psychology (HCP) to _____ release/ _____ obtain the protected health information of

_____ Patients Name Birthdate

To: _____

For the purpose of: (Please initial next to box)

- _____ Coordination of Care _____ Administrative (Billing, Scheduling)
- _____ At the request of the individual _____ Insurance
- _____ Legal Purposes
- _____ Other _____

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 HCP 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 determination, underwriting or risk rating determinations.

I understand that I may revoke this authorization at any time by notifying HCP, 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 HCP 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 HCP.

Patient's Name (printed)

Clinical Psychologist Signature

Patient's Signature

Date _____

Date _____