Urgent Care Hawaii
where amazing healthcare happens

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name:_____ **Date of Birth**:_____

Patient Mailing Address:_____

Street Address *City/State/Zip Code*

Please check off all that apply:

- ❑ **May leave detailed message on telephone answering machine at home number:**_____
- ❑ **May leave detailed message on voicemail at work number:**_____
- ❑ **May leave information with Spouse (name):** _____
- ❑ **May leave information with other family member (name):**_____
- ❑ **May leave detailed message on cellular phone number:**_____
- ❑ **May leave detailed message at a different location number:**_____
- ❑ **May send detailed message by email to:** _____

Email address

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify URGENT CARE HAWAII, LLC should I change one or more of the telephone numbers listed above OR any one of the contact names.

_____
Print Name

_____ _____
Patient or legally authorized individual signature **Date**

Please turn page over
More information is needed on the other side

AUTHORIZATION FOR RELEASE AND DISCLOSURE OFPROTECTED HEALTH INFORMATION

Your privacy is important to URGENT CARE HAWAII, LLC. As a result, we ask you to complete the following authorization related to your personal health and health-related benefits.

I hereby authorize use and disclosure of protected health information (PHI), as described below.

Please PRINT all information legibly.

This Authorization relates only to the PHI of:

NAME:_____**Last four digits of Social Security Number:** _____

I hereby authorize URGENT CARE HAWAII, LLC to release information about my account (phone number, address, vists at the center, etc.) at URGENT CARE HAWAII, LLC to the following people:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

I hereby authorize URGENT CARE HAWAII, LLC to release information about my medical treatment (PHI) to the following people:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

I have read and understand the following statements about my rights:

A) I may revoke this authorization at any time by giving written notice to URGENT CARE HAWAII, LLC. I understand that my revocation will not affect any use or disclosure of my PHI that was made in reliance on the authorization before I revoked it.

B) My health provider cannot require me to sign this authorization in order to be eligible for services or treatment.

C) It is possible that the persons who receive information based on this authorization may disclose it to others and as a result the information may no longer be protected by federal privacy rules.

D) This Authorization for my personal health information does not apply to the release of the same information for any spouse or child that I may cover on my medical benefits or account at URGENT CARE HAWAII, LLC. I understand that my spouse or child over 18 must provide independent Authorization for release of their personal PHI.

I acknowledge that I have received and signed a copy of this authorization.

SIGNATURE:_____**DATE:** _____