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AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION AND RECORDS

IMPORTANT: THIS AUTHORIZATION DEALS WITH THE RELEASE, SHARING, DISCLOSURE, AND RECEIPT OF INFORMATION FROM YOUR MEDICAL AND HEALTH CARE RECORDS. READ IT CAREFULLY.

You must complete each section where there is an arrow ► symbol

I, ►_____ , of ►_____
(Patient or Patient's Personal Representative) (Address)

►_____ ►_____
(Date of Birth) (City, State, Zip code)

hereby authorize any health plan, physician, health care practitioner, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to (Patient Name) ►_____ to release, disclose and furnish copies of the following medical and health care information regarding my care and treatment to Regulated Industries Complaints Office, its agents and/or its attorneys (hereinafter referred to as "RICO").

By checking below, I authorize access and limit the authorization to the records described below **(PLEASE CHECK ONE ONLY):**

☐ Records regarding admission and treatment for the following medical condition or injury:

_____ on or about _____
(Condition or Injury) (Date of Service)

☐ Records from the period from _____ to _____

☐ Records confined to the following specified information:_____

☐ I am unable to recall specific treatment dates. Please disclose health information and records for the dates of any treatment I received.

(OVER)

By **initialing** below, I also authorize release of the following portions of the health care records/information.

_____ Mental Health Treatment Records (NOTE: This authorization does not include psychotherapy notes)

_____ HIV or AIDS related records

_____ Alcohol or drug abuse records (NOTE: Applicable only if substance abuse records are disclosed. The information disclosed includes records protected by federal confidentiality rules 42 CFR, part 2. The rules prohibits recipients of such records from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. The general authorization for the release of medical or other information is NOT sufficient for this purpose). If you initial this item, we will send you an additional authorization form to sign.

Term of Authorization: This Authorization is effective from the date I have signed it until the conclusion of RICO's civil or administrative actions, including but not limited to any appeals and any derivative matters or needs.

Revoking the Authorization: I have been advised that I have the right to revoke this authorization by contacting RICO in writing to request that this authorization be cancelled. If I revoke this authorization, the revocation will not apply to records or information that have been released before I notified the record keeper or RICO in writing of my change of mind, and will not apply to records that RICO has relied upon in taking action against a health care practitioner. I understand that my decision to revoke this authorization may impair RICO's ability to investigate a complaint and to pursue disciplinary action against a health care practitioner, and my complaint may be dismissed.

Redisclosure: I understand that the information used and disclosed in accordance with this authorization may be subject to redisclosure by RICO and may no longer be protected by the federal privacy rule. For example, RICO may disclose my records/information to the health care practitioner that is the subject of a law enforcement or oversight matter relating to my health information or his or her attorney; or to a consultant working for RICO or the health care practitioner. My records/information may also be disclosed to me, RICO's personnel, authorized agents or other representatives; any reviewing board, commission, or program; its personnel, authorized agents or other representatives; reviewing Advisory Committee Members and experts retained by RICO; the State of Hawaii Department of Commerce and Consumer Affairs Office of Administrative Hearings and its administrative personnel; other law enforcement agencies with civil or criminal jurisdiction over matters relating to the protected health information; and any other deliberative and/or reviewing bodies.

Purpose of disclosure: I understand that a number of state licensing boards including the Board of Medical Examiners of the State of Hawaii issues licenses to provide health care in the State of Hawaii. RICO, on behalf of the various boards, investigates complaints or reports regarding health care practitioners including physicians and physician assistants in order to determine whether disciplinary or other legal action is needed in order to protect patients and the public interest. I understand that my records and information may be used to perform investigation, prosecution and oversight of health care practitioners as may be required under applicable state and federal laws, including but not limited to the state's professional and vocational licensing laws. A photocopy of this authorization shall be considered as effective and valid as the original.

►_____ ►_____

(Signature of Patient or Patient's Personal Representative) (Date)

►_____

(Print Name of Patient or Patient's Personal Representative)

If applicable, please describe how you are authorized to act as the Personal Representative of the Patient **(and attach verification of authority).**

_____