STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
REGULATED INDUSTRIES COMPLAINTS OFFICE
CONSUMER RESOURCE CENTER
OAHU OFFICE
235 SOUTH BERETANIA STREET, 9TH FLOOR
HONOLULU, HI 96813
cca.hawaii.gov/rico

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND MEDICAL INFORMATION

WHOSE records to be disclosed:

Name of Patient (Last, First, Middle):	Patient's Date of Birth:

Name of Patient or Person Signing Authorization Form on Behalf of Patient (Last, First, Middle):

I hereby authorize any treating health care provider, hospital, pharmacy or other facility to release the following records and information about the above-named patient to the Department of Commerce and Consumer Affairs' Regulated Industries Complaints Office ("RICO"):

(CHECK <u>ONE</u> – FORMS WITH MORE THAN ONE OPTION SELECTED WILL BE RETURNED)

☐ Records related to the admission and treatment for the following medical condition or injury: _____ _____ that occurred on or about: _____.

or

☐ Records for the following time frame: from _____ to _____.

or

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

Records and information include:

(CHECK ALL THAT APPLY)

☐ **Mental Health Treatment Records** (Does not include psychotherapy notes)
☐ **HIV or AIDS related records**
☐ **Alcohol or drug abuse records** (*If you check this item, an additional authorization form will be sent to you*)
☐ **None** of the above

ADDITIONAL INFORMATION AND SIGNATURE OF THE PATIENT

Purpose of This Authorization: I understand that my records and information may be used to perform investigation, prosecution, and general oversight of health care practitioners as may be required under applicable state and federal laws, including but not limited to Hawaii's professional and vocational licensing laws. I understand that my records and information may also be used to perform investigation, prosecution, and general oversight over possible unlicensed activity that may be occurring in the State.

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

KEEP READING! AN <u>ORIGINAL</u> SIGNATURE IS REQUIRED ON THE BACK OF THIS FORM

Action Required to Revoke This Authorization: I understand I have the right to revoke this authorization by sending written notice to RICO at the above address. I understand any revocation will not apply to records or information already released or relied on by RICO in an action against a health care practitioner.

Redisclosure of Records and Information by RICO: I understand records and information obtained with this authorization may be redisclosed by RICO as part of RICO's investigation or prosecution of possible allegations related to my complaint, including to the health care practitioner that is the subject of a law enforcement or oversight matter and any attorney who may represent the practitioner; to an expert or consultant working for RICO or the health care practitioner; to a reviewing board, commission, or program, its personnel, and its authorized agents or other representatives; to the State of Hawaii Department of Commerce and Consumer Affairs Office of Administrative Hearings and its administrative personnel; to other law enforcement agencies with civil or criminal jurisdiction over matters relating to the protected health information; and to any other deliberative and/or reviewing bodies. I understand redisclosure to non-health oversight agencies may no longer be protected by federal privacy regulations.

I understand copies of this Authorization distributed by RICO shall be considered as effective as the original.

►_____ ►_____

(Original Signature of Patient) (Date)

COMPLETE THIS SECTION IF YOU ARE SIGNING ON BEHALF OF THE PATIENT

I certify I have authority to authorize the release of the above-named patient's medical records and information

- ☐ as the patient's custodial parent;
- ☐ as the patient's guardian;
- ☐ by legal power of attorney (copy of legal document demonstrating power of attorney must be attached); or
- ☐ as the patient's next of kin* (please describe _____).

I certify this information is true and correct to the best of my knowledge.

►_____ ►_____

(Original Signature of Patient Representative) (Date)

►_____

(Print Name of Patient Representative)

*Hawaii Revised Statutes section 622-57(c) permits a personal representative to obtain a decedent's medical records. If no personal representative exists, the decedent's next of kin in superseding priority is authorized to obtain the records in the order of adult child, parent, adult sibling, grandparent and guardian at the time of death. When there are multiple persons at the same level of superseding priority, all such persons shall be entitled to request and obtain the records. The person claiming to be next of kin of a deceased person and requesting the deceased person's medical records shall submit to the medical provider from whom the records are requested, an affidavit attesting to status as next of kin with superseding priority. The medical provider may rely upon the affidavit, and in so doing, shall be immune to any claims relating to release of the medical records.

DCCA Department of Commerce and Consumer Affairs
Regulated Industries Complaints Office

Mail completed Authorization forms to:

Regulated Industries Complaints Office
Attention: Consumer Resource Center
235 South Beretania Street, 9th Floor
Honolulu, Hawaii 96813

Authorization forms are accepted at neighbor island RICO offices for mailing.

This material is available in alternate formats including large print.
For assistance, please contact the RICO Complaints and Enforcement Officer at 586-2666.