## Hawaii State Department of Health

# Authorization for Use or Disclosure of Protected Health Information (PHI)

| **Individual/Organization Disclosing Protected Health Information** | |
|---|---|
| Name:<br>Medical Provider Name | Address:<br>Medical Provider address |
| **Individual/Organization That Will Receive the Individual's Protected Health Information** | |
| Name:<br>State of Hawaii / Department of Health / Public Health Nursing | Address:<br>PHN Section address |
| **Individual Whose Protected Health Information Is Being Requested** | |
| First Name: | Last Name: |
| Address: | Birthdate (if known): |

**I Authorize That the Following Protected Health Information Be Used or Disclosed** (be specific and identify limits, as appropriate. Initial in the space provided if this Authorization includes the use or disclosure of specially protected health information):

Exchange of information regarding student's condition: _____, including medication, treatment, and any prescriptions that need to be addressed in the school setting.

_____ Mental Health _____ Substance Abuse Treatment _____ HIV/AIDS

**The Protected Health Information Is Being Used or Disclosed for the Following Purpose(s)** ("At the request of the individual" is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose):

( X ) Development of an Emergency Action Plan, as needed.
( X ) Administration of Medication
( ) _____

**Authorization Duration** (This Authorization will be enforced and in effect until the date **OR** event specified below. At that time, this Authorization to use or disclose this Protected Health Information expires);

Authorization Expiration Date **OR** Event:

Upon exit from State of Hawaii / Department of Education.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the Department of Health. I understand that a revocation is not effective to the extent that the Department has relied on the use or disclosure of the Protected Health Information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA, 34 CFR Part 99) and alcohol or drug treatment services (42 CFR Part 2) may not be disclosed or redisclosed without my authorization.

The entity or person(s) receiving this information will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating Protected Health Information for disclosure to a third party.

The use or disclosure requested under this Authorization will result in direct or indirect remuneration to the Department from a third party.
(Check this box ONLY if the disclosing party will receive compensation or other benefit when using or disclosing this Protected Health Information). ☐

| Individual or Personal Representative Signature: | Date: |
|---|---|
| Print Name of Individual or Personal Representative: | Description of Personal Representative's Authority: |