

UNIVERSITY OF HAWAII
[UH COVERED COMPONENT]

Patient Consent for Use and Disclosure of Protected Health Information

I _____ hereby give my consent for [UH COVERED COMPONENT] to use and disclose protected health information ("PHI") about me to carry out treatment, payment and health care operations ("TPO").

(The Notice of Privacy Practices provided to me by [UH COVERED COMPONENT] describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. [UH COVERED COMPONENT] reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to [Name and Address of UNIT HIPAA COORDINATOR for the UH COVERED COMPONENT].

With this consent, [UH COVERED COMPONENT] may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the organization in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, [UH COVERED COMPONENT] may mail to my home or other alternative location any items that assist the organization in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, [UH COVERED COMPONENT] may email to my home or other alternative location any items that assist the organization in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that [UH COVERED COMPONENT] restrict how it uses or discloses my PHI to carry out TPO. The organization is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow [UH COVERED COMPONENT] to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the organization has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, [UH COVERED COMPONENT] may decline to provide treatment to me.

Signature of Patient or Parent/Legal Guardian

Print Patient's Name

Date

Print Name of Parent or Legal Guardian (if applicable)