INDIVIDUAL PATIENT'S AUTHORIZATION

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

1. I give my authorization to use or disclose my protected health information as described in section 2 below. I give this authorization voluntarily.

Name: ____
(last) (first) (middle)

Address: ____
(street) (apt #)

____
(city) (state) (zip)

SSN: _________-_________-_________ DOB: _____/_____/_____

2. **To:** Names the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information.

   REQUESTING AGENCY & ITS DESIGNEES & INVOLVED ATTORNEYS

   From: Names the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or to disclose the protected health information described above.

   HONOLULU SPORTS MEDICAL CLINIC INC.

   What: Describes in detail the protected health information you are authorizing to be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed here):

   IME REPORT & SUPPORTING DOCUMENTS

   Why: Describes the purpose for which you are authorizing your protected health information to be used and/or disclosed.

   MY CLAIM

3. **Ending this authorization:**
   This authorization for disclosure remains in effect until I advise in writing otherwise.
   I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at this office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

4. I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Date: _____/_____/_____ **Signature** ______________________________

*Representative's Name: ______________________ Relationship to Patient: ______________________
*If this authorization form is signed by a personal representative for the individual patient:

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.