ATTACHMENT 1

AUTHORIZATION AND WAIVER FOR RELEASE OF INFORMATION
(Sample – General Release)

I authorize _____ ("Care Provider") to provide the
Name of Care Provider or Facility
following information to the State of Hawai`i, *<Department Name, Department Representative, and Address>* for *<Describe intended use of information>*.

Information to be disclosed: *<Describe requested information>*

I understand that:

- I may revoke this authorization by notifying the Care Provider **in writing** of my revocation.
- A revocation will not apply to any information that was already released under this authorization.
- The Facility will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for:
  (i) research-related treatment; or
  (ii) health care provided solely for disclosure to a third party; or
  (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.
- The health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.
- A photocopy of facsimile of this authorization shall have the same effect as the original.

This authorization is valid until the *<Reason for the information>* or until the undersigned revokes this authorization in writing, whichever event first occurs. If applicable and allowed by law, I waive all requirements and provisions of the Federal Privacy Act (5 U.S.C. §552, 552 (a), et. seq.) and all other laws and regulations.

Employee Name _____
(Please Print) First Middle Initial Last

Employee Signature _____ _____
Date

Social Security Number_____ Birth Date_____

Employee's Representative_____
(Please Print) First Middle Initial Last

Relationship to Employee_____