

King Lunalilo Adult Day Care Center

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, authorize King Lunalilo Adult Day Care Center and Lunalilo Home to disclose health information relating to my health, disability or illness condition to the following individual or entity:

(Please initial for authorization)

_____ King Lunalilo Adult Day Care Center and Lunalilo Home.

_____ My physician or other provider giving medical services in an emergency situation involving me.

_____ Other _____

For the following purposes:

- To provide the medical resources I may require and/or in a medical emergency situation.
- To be used as required or permitted by various state and federal laws;
- Other entities may use your health information for purposes of payment; conducting quality assurance activities or outcomes assessments; reviewing the competence or qualifications of health care professionals; performing accreditation, licensing, or credentialing activities; analyzing health plan claims or health care records data; evaluating provider clinical performance; carrying out utilization management; or conducting or arranging for auditing services in accordance with statute, rule or accreditation requirements.

This consent to disclose health information begins effective immediately. I understand that I can revoke this authorization in writing at any time, but it is valid until revocation in writing.

Signed _____

Date _____

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I, _____, authorize my physician or other provider giving me medical services relating to my health, to disclose health information relating to my health, disability or illness condition King Lunalilo Adult Day Care Center and Lunalilo Home the following purposes:

- To provide the medical resources I may require and/or in a medical emergency situation.
- To obtain information about my health and medical history for possible participation in the Adult Day Care Program at Lunalilo Home.
- To be used as required or permitted by various state and federal laws;
- Other entities may use your health information for purposes of payment; conducting quality assurance activities or outcomes assessments; reviewing the competence or qualifications of health care professionals; performing accreditation, licensing, or credentialing activities; analyzing health plan claims or health care records data; evaluating provider clinical performance; carrying out utilization management; or conducting or arranging for auditing services in accordance with statute, rule or accreditation requirements.

This consent to disclose health information begins effective immediately. I understand that I can revoke this authorization in writing at any time, but it is valid until revocation in writing.

Signed _____

Date _____