

**AUTHORIZATION FOR DISCLOSURE AND USE OF  
PROTECTED HEALTH INFORMATION**

**I. PERSON OR ENTITY AUTHORIZED TO DISCLOSE MY PROTECTED HEALTH INFORMATION:**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**II. INDIVIDUAL WHO IS THE SUBJECT OF THE PROTECTED HEALTH INFORMATION:**

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

**III. IDENTITY OF PERSONS AND ENTITIES TO WHOM MY PROTECTED HEALTH INFORMATION CAN BE DISCLOSED:**

Myself and my duly appointed representative;

Fairmont Specialty and its respective adjusters, employees, consultants, agents, duly appointed representatives, nurse case managers, and independent contractors;

Federal/State Judicial and Administrative Tribunals and their administrative personnel and employees with jurisdiction over my claim, and any person the presiding judge or official permits to be present in the courtroom or administrative tribunal (e.g. jurors, witnesses, etc.);

Physicians, nurses, and other health care providers and their respective employees, consultants and independent contractors for the purpose of treatment, medical evaluation, consultation, review and medical management;

Parties in my workers' compensation claim and such parties' attorneys, employees, consultants, agents, duly appointed representatives, independent contractors, insurance carrier(s), and insured;

Expert witnesses retained by the parties or consulted by the parties in my workers' compensation claim, provided that such expert witnesses maintain the confidentiality of my protected health information;

Vocational rehabilitation counselors and their respective employees, consultants, agents, duly appointed representatives, and independent contractors for the purpose of rehabilitation plan development and administering, analyzing assessing evaluating, examining, investigating, and reviewing job suitability and job placement.

**IV. PURPOSE FOR THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION:**

I authorize disclosure of my protected health information to all persons and/or entities identified in Part III of this authorization for the purpose of administering, analyzing, assessing, evaluating, examining, investigating, reviewing and/or contesting my medical condition and my entitlement to benefits and/or damages in my workers' compensation claim(s) designated as claim number \_\_\_\_\_, Case No(s) \_\_\_\_\_ as my medical condition is at issue in said claim.

I further authorize a private photocopy company or court reporter to photocopy such records as requested above.

**V. NATURE OF THE PROTECTED HEALTH INFORMATION TO BE DISCLOSED:**

I hereby authorize you to furnish my entire record of protected health information, including but not limited to, all information, notes and reports concerning illnesses or injuries, physical and health care records, opinions, consultations, operations, history and physical examinations, emergency room/department services, laboratory tests/results, diagnostic scans, x-ray/imaging, billings, prescriptions, therapy, discharge summary, history and physical, and rehabilitation that may relate to or bear upon the workers' compensation case(s) identified in Part IV.

\_\_\_\_\_(initial) **I also agree to the release of the following information under the same conditions as stated above should it be contained in my medical record: alcohol and/or drug abuse treatment, behavioral or mental health services, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV), and other infections, communicable diseases or conditions described in Chapter 325, Hawai'i Revised Statutes. (I understand that this information will not be disclosed if I do not specifically agree to disclosure.)**

**VI. AUTHORIZATION AND CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION VALID UNTIL WORKERS' COMPENSATION CASE IS CLOSED OR IS REVOKED BY ME:**

I understand that I can revoke this authorization and consent to disclose protected health information at any time upon written notification to Fairmont Specialty, 733 Bishop Street, Suite 2200, Honolulu Hawaii 96813 and that my revocation is limited to the extent that it will not apply to any information that was already released in reliance on this authorization. I understand that this authorization and consent to disclose protected health information shall be valid until 1) the date of termination/closing of the workers' compensation case(s) identified in Part IV and will then expire without my providing a written notice of revocation; or 2) the date that Fairmont Specialty or the person or entity identified in Part I receives my written notice of revocation.

**VII. ACKNOWLEDGMENT AND RELEASE**

I hereby acknowledge that I have read this document and fully understand its contents in its entirety. I understand and acknowledge that my written authorization constitutes an express waiver of any rule against disclosure as provided by any confidentiality provision of any federal, state, or other applicable law, including but not limited to Hawai'i Revised Statutes Chapter 325 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and that I have waived any privilege I have to the information being released. I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I understand that I can refuse to sign this authorization and the person or entity authorized to disclose my protected health information that is identified above 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 research-related treatment, health care provided solely for disclosure to a third party or health plan initial enrollment eligibility determinations, underwriting or risk rating determinations.

I hereby release the person or entity authorized to disclose my private information identified in Part I from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by the person or entity identified in Part I.

A photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

\_\_\_\_\_ Printed Name