AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION (PHI)
TO AUTHORIZED PERSONS BY PATIENT

It is our policy not to release confidential medical information to family members or friends, except for parent and/or legal guardian, if the patient is a minor, or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members or other persons, please complete the following information.

Patient Name: ________________________________ **Date of Birth:** ___________________

This authorization is voluntary. I may revoke this authorization in writing and it will not effect any actions already taken by Rebound Hawaii LLC and /or Business Associates based upon this authorization.

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Signature of Patient or Legally Authorized Individual Date

Check one of the following:

- ❑ **I DO NOT want my Personal Health Information (PHI) to be provided to family members or other persons.**

--- OR ---

- ❑ **I hereby authorize Rebound Hawaii LLC and/or Business Associates to disclose the following (please check the appropriate box(s) below):**
  - o My Personal Health Information such as information regarding my condition and/or treatment.
  - o My Financial Information such as billing, payment, updating my insurance information
  - o Other:____

To the following authorized person(s):

1) ____ _______________________

Print Name of Authorized Person #1 Relationship

____ _______________________

Address Contact Phone Number

____

Email or Alternative Method of Communication

2) ____ _______________________

Print Name of Authorized Person #2 Relationship

____ _______________________

Address Contact Phone Number

____

Email or Alternative Method of Communication