HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

Patient Permitted Communication List Form

INSTRUCTIONS: This form may be used to allow Hawai'i Pacific Health (HPH) to communicate information about you with persons listed below who are involved in your care. Your permission to communicate with persons involved in your care applies to all HPH facilities. You may submit/mail/fax this form to any of the following HPH facility:

Kapi'olani Medical Center for Women & Children
1907 South Beretania Street, Honolulu, HI 96826
Phone: 808-983-8610 | Fax: 808-983-8210

Kapi'olani Women's Center, Artesian Plaza
1907 South Beretania Street, Honolulu, HI 96826
Phone: 808-983-8610 | Fax: 808-983-8210

Pali Momi Medical Center
98-1079 Moanalua Road, Aiea, HI 96701
Phone: 808-485-4181 | Fax: 808-485-4372

Straub Medical Center
888 S. King Street, Honolulu, HI 96813
Phone: 808-522-4285 | Fax: 808-522-3207

Wilcox Memorial Center
3-3420B Kuhio Highway, Lihue HI 96766
Phone: 808-245-1128 | Fax: 808-245-1058

Kaua'i Medical Clinic
3-3420B Kuhio Highway, Lihue HI 96766
Phone: 808-245-1128 | Fax: 808-245-1058

Patient Name (First, Middle Initial, Last):	
Date of Birth: __ __/__ __/__ __	Tel. No.: (_____) _____ - _____
Address:	

I understand HPH will only disclose my/my child's information to those involved in my/my child's care, with my permission, or as permitted or required by law. I therefore give HPH permission to discuss my/my child's information to the person(s) listed and for the purposes described below**. I understand this permission does NOT allow or authorize person(s) on my permitted communication list to have full and direct access to my/my child's medical records or to make health care decisions for me/my child.**

Name	Relationship (friend, family, caregiver)	Phone Number
1.		
2.		
3.		

Scope of Permission: All HPH facilities may discuss the following information: a) financial information for billing and payment purposes, b) appointment information for scheduling and verifying purposes, c) registration and insurance information for updating and verifying purposes; and, d) health information limited to what the person involved needs to know about the visit, service or item, such as your discharge instructions, medication management or treatment plan.

Sensitive Information: I understand that if my records contain sensitive information such as drug/alcohol abuse, mental health, or HIV/AIDS status, then HPH may share the minimum amount of sensitive information with those on my/my child's permitted communications list if, and only if, necessary and within the scope of this permission.

Cancellations/Updates: I may cancel or update my permitted communication list by notifying HPH. I understand that this permission is effective until cancelled or updated by me, however, such changes will not apply to any information released prior to receipt. I understand this form supersedes any prior form or permission given by me.

Signature:	Print Name:	Date:
If you are not the Patient, please describe your legal authority:		

For Facility use only: ☐ Verbal Request by Patient/Patient Representative

Medical Record Number: _____ Date Received: _____ Date Recorded: _____