HAWAI'I HEALTH
& HARM REDUCTION CENTER

Reducing harm, promoting health, creating wellness, and fighting stigma in Hawai'i and the Pacific

REFERRAL FOR HIV MEDICAL CASE MANAGEMENT

TODAY'S DATE

PLEASE FAX COMPLETED FORM TO (808) 626-5036.

REFERRING STAFF INFORMATION	CLIENT INFORMATION
NAME:	**NAME:**
AGENCY:	**DOB:**
CONTACT:	**CONTACT:**
	BEST TIME TO CONTACT: AM/PM

IMPORTANT: *This form contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This information is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this form to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.*

Authorized Disclosure:

As the individual named above, I authorize **[your agency name]** to release copies of, discuss verbally, and obtain copies of, my Protected Health Information to/from: Hawaii Health & Harm Reduction Center (HHHRC) for the purposes of HIV case management. I understand that this information will be used or disclosed for the purposes of referral from **[your agency name]** to HHHRC for services.

Duration of Authorization:

This authorization shall remain valid *either* for two (2) years from the date of signing *or* **until I submit written notification** to **[compliance officer],** at **[your agency name and address]** that I wish to revoke this authorization, *whichever occurs first.*

I understand that I am not required to provide this authorization and that if I do not provide this authorization **[your agency name]** cannot arrange to have someone from HHHRC contact me, I understand I may revoke this authorization at any time as described above.

CLIENT SIGNATURE		DATE	

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