Authorization for Use or Disclosure of Protected Health Information (PHI)

Organization Disclosing PHI	Name of Individual/Organization (other than AMHD) Disclosing PHI
Name: State of Hawaii Adult Mental Health Division (AMHD) PO Box 3378 Honolulu, HI 96801-3378	Name: ______________________ ______________________ ______________________ ______________________

Organization That Will Receive the Individual's PHI

Hawaii Police Department
349 Kapiolani Street
Hilo, HI 96720

Client/Patient Whose PHI is Being Requested

First Name:	Last name:
Address: ______________________ ______________________ ______________________	Birth date: Social Security Number:

I Authorize that the Following Protected Health Information be Used/Disclosed: **(PLEASE INITIAL)**

_______Mental Health _______Substance Abuse Treatment and/or Counseling

The Protected Health Information is Being Used or Disclosed for the Following Purposes *(At the request of the Individual is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose.)*:

To determine my qualification to own, possess, or control any firearm or ammunition.

Authorization Duration (This authorization will be in force and effect until the event specified below. At that time, this authorization to use or disclose this protected health information expires).

Expiration of Authorization Event That Relates to the Purpose of the Use or Disclosure:

My disqualification from owning, possessing, or controlling any firearm or ammunition.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above stated county police department. I understand that a revocation is not effective to the extent that the county police department has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA, 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be redisclosed without my authorization.

Signature.	Date:
Print Name:	