HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, ______________________________, identified below as the "Applicant," do freely and in compliance with Hawai'i Revised Statutes §§ 134-2, 134-7, and 134-9, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and any other laws, ordinances, rules, or regulations protecting the privacy of mental health information, authorize the release of all mental health (including psychiatric and behavioral health) information and all substance abuse (alcohol and drug) information from all medical sources, including but not limited to all health care providers, health care plans, and government entities, for the ten years preceding and five years following the date of my signature below, to Records and Identification Section, Hawai'i Police Department (HPD), 349 Kapiolani Street, Hilo, HI, 96720, for the purpose of determining my qualifications to acquire, own, possess, have under my control, and/or carry publicly, a firearm. I authorize and allow the re- disclosure of the information requested and provided pursuant to this authorization, to the full extent permitted by law, to persons involved in reviewing my mental health background and determining my appropriateness for the firearm application I have filed and for purposes of any legal proceedings that may be filed regarding my application.

I understand that the health information released under this authorization may be re-disclosed by the HPD without my permission, including information which may otherwise be subject to limitations on redisclosure under SAMHSA, 42 CFR Part 2, and may no longer be protected under the HIPAA privacy regulations or other privacy laws.

This authorization expires five years from the date of my signature unless earlier revoked by me in writing. I understand that I have the right to revoke my authorization by submitting a written revocation to the Firearms Unit, HPD. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization.

I understand that my health care providers/health plans will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization, except as allowed by law.

The HPD may make copies of this authorization, and I agree that any recipient of a copy (digital or otherwise) of this authorization provided by the HPD may treat it as an original signed authorization.

I understand that this authorization does not constitute a permit or a license to acquire, own, possess, have under my control, and/or carry publicly, a firearm.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my voluntary authorization for the use, request, and release of my protected health information, as described in this authorization.

Applicant:

_______________ ____

DATE SIGNATURE OF APPLICANT

_______________ ____

APPLICANT'S DATE OF BIRTH FULL NAME OF APPLICANT (PRINTED)

HPD Witness:

_______________ ____

DATE SIGNATURE OF HPD WITNESS

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NAME OF HPD WITNESS (PRINTED)