Pu‘ulu Lapa‘au
Hawai‘i Program for Healthcare Professionals
200 North Vineyard Blvd, Bldg B, Suite 271
Honolulu, HI 96817
Tel: 808-593-7444 • Fax: 808-593-8999
Website: www.hawaiiphp.org

CONSENT & AUTHORIZATION TO DISCLOSE PROTECTED INFORMATION

I hereby authorize release of protected information as described below:

1. Program Participant's Identity	_____ Name Date of Birth
2. Persons/Entities Authorized to Release Protected Information	Pu`ulu Lapa`au, a Hawai`i nonprofit corporation, whose principal place of business and address is: 200 North Vineyard Blvd, Bldg B, Suite 271, Honolulu, HI 96817.
3. Protected Information May Be Released To and From:	To and From: Pu`ulu Lapa`au AND:
4. What May Be Disclosed	Any information regarding any Condition (including without limitation alcohol or other substance abuse) I may have which could potentially interfere with my ability to engage safely and properly in professional activities as a Healthcare Provider or any inability on my part to practice medicine with reasonable skill and safety due to said Condition.
5. Separate Additional Authorization	I specifically consent to and authorize the release of any and all information relating to: ☒ psychological and/or psychiatric care or counseling, including psychotherapy ☒ drug and/or alcohol abuse treatment **Signature:** _____ **Date:** _____ Healthcare Provider Date Signed
6. Expiration Date	This Authorization is valid for five years from the date of execution, unless withdrawn as set forth below.
7. Purpose of Disclosure	Assistance to the above recipient of information to assess my qualifications and ability to render professional services as a Healthcare Provider, including whether or not grant, suspend, terminate privileges, licenses or permission to render professional services as a Healthcare Provider in connection with or relation to the above recipient or in general.
8. Right of Revocation	I understand that I have the right to revoke this authorization at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate after completion of monitoring with Pu`ulu Lapa`au or upon 5 years from the date it is signed.
9. Further Conditions	A photocopy, fax or emailed PDF of this authorization is as effective and valid as the original.

Signature: _____ **Date:** _____
Healthcare Provider Date Signed

Witness: _____ **Date:** _____
[name of person signing] Date Signed