## 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 Individuals PHI	
Kaua`i Police Department 3990 Kaana Street, Suite 200 Lihue, HI 96766	
Client/Patient Whose PHI is being Requested  First Name:	Last Name:
riist name.	
Address:	Birthday:
	Social Security Number:
I, Authorize that the Following Health Information be Used/Disclosed: (Please Initial Below)	
Mental Health Substance Abuse Treatment and/or Counseling The Protected Health Information is Being Used or Disclosed for the Following Purpose (At the request of the Individual is an acceptable purpose of the request made by the individual and the individual does not want to state specific purpose)  To determine my qualifications to own, possess, or control any firearm or ammunition.	
Authorize Duration (The 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 (FERPTA, 34 CFR, Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be re-disclosed without my authorization.	
Signature:	Date:
Print Name:	

AG.Firearms.Waiver.Kauai 9/2013