HĀMĀKUA-KOHALA HEALTH

Caring for your 'ohana, Caring for you

HOW DID YOU HEAR ABOUT US? Please Circle ONE

·Friend ·Newspaper Ad
·Website ·Community Event
·Flyers/Brochures ·Other media (TV, radio)
·Social Media (FaceBook, Instagram, YouTube)

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____ City: _____ State: ___ Zip code: _____

Residence Address: _____ City: _____ State: ___ Zip code: _____

Home phone: (___) _____-_____ Work Phone: (___) _____-_____ Mobile Phone: (___) _____-_____

Date of Birth: __ __/__ __/ __ __ __ __ E-mail Address: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Employer: _____

RESPONSIBLE PARTY INFORMATION

[ ] Check if the information is the same as the patient listed above

First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____ City: _____ State: ___ Zip code: _____

Home phone: (___) _____-_____ Work Phone: (___) _____-_____ Mobile Phone: (___) _____-_____

Date of Birth: __ __/__ __/ __ __ __ __ Gender: [ ] F [ ] M Relationship to Patient:_____

The co-pays or charges are based on an estimated charge and will be fully documented by your provider after the visit. Any additional charges not covered by your insurance may be billed to you.

INSURANCE INFORMATION

****If you have your insurance card please provide it to our staff and leave the following section blank****

Primary Insurance	Secondary Insurance
Insurance Carrier: _____	Insurance Carrier: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Number: _____	Subscriber Number: _____
Mailing Address: _____	Mailing Address: _____
_____	_____
Subscriber's Date of Birth: __ __ /__ __/ __ __ __ __	Subscriber's Date of Birth: __ __ /__ __/ __ __ __ __

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PHARMACY INFORMATION

Preferred Pharmacy Name: _____ Location: _____

EMERGENCY CONTACT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Home phone: (___) _____-_____ Work Phone: (___) _____-_____ Mobile Phone: (___) ____-_____

Relationship: _____ May we speak to this person about your health? ____ Yes ____ No

NAME: _____ **DOB**: _____

ADDITIONAL INFORMATION

As a Federally Qualified Health Center, we are required to annually report on the populations we serve. Please remember that your answers are strictly confidential.

Which of the following income categories best describes the total monthly income for your family?

- ☐ $0-$999
- ☐ $1,000-$1,999
- ☐ $2,000-$2,999
- ☐ $3,000-$3,999
- ☐ $4,000-$4,999
- ☐ $5,000-$5,999
- ☐ $6,000-$6,999
- ☐ $7,000-$7,999
- ☐ $8,000+

How many people are supported by that income? _____

What sex were you assigned at birth? ☐ Male ☐ Female

What is your Sexual Identity?

☐ Straight or Heterosexual ☐ LGBTQ ☐ Choose not to disclose/don't know ☐ Other: _____

What is your Gender Identity?

- ☐ Male
- ☐ Transgender Male
- ☐ Unknown
- ☐ Female
- ☐ Transgender Female
- ☐ Other: _____

Primary Language: (Select One):

- ☐ English
- ☐ Spanish
- ☐ Tagalog
- ☐ Ilocano
- ☐ Hawaiian
- ☐ Marshallese
- ☐ Japanese
- ☐ Chinese
- ☐ Sign
- ☐ Other:

Do you need an Interpreter? ☐ Yes ☐ No

Are you Hispanic? ☐ Yes ☐ No

If yes, please select the option that best describes you

- ☐ Mexican, Mexican American, Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ Hispanic, Latino/a, Spanish origin, combined

What is your Most Prominent Ethnicity (Select One)?

- ☐ Caucasian
- ☐ Japanese
- ☐ Hawaiian
- ☐ Filipino
- ☐ Chinese
- ☐ Korean
- ☐ Portuguese
- ☐ Samoan
- ☐ Pacific Islander
- ☐ Marshallese
- ☐ Puerto Rican
- ☐ Micronesian
- ☐ American Indian
- ☐ African American
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Hispanic
- ☐ Other: _____

Housing (please select one)?

- ☐ Homeowner
- ☐ Staying with Family
- ☐ Public Housing
- ☐ No Home/In Transition
- ☐ Renter
- ☐ Staying with Friend(s)
- ☐ Senior Housing

Are you a Veteran? ☐ Yes ☐ No

Agricultural Worker ☐ None ☐ Employed Year Round ☐ Seasonal ☐ Migrant ☐ Retired

Citizenship Status: ☐ US Citizen ☐ Immigrant ☐ Permanent Resident/Alien ☐ Other: _____

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AUTHORIZATION AND RELEASE

I consent to Medical Services, Dental Services and Behavioral Health Services, Cultural Health Services (including voluntary family planning services) under the direction of the provider for which I or my dependent, have sought care. I understand that no treatment/procedure other than ordinary medical/dental behavioral health procedures will be done to me or my dependent without specific consent.

Patient name:_____ DOB: _____

I give Hamakua Health Center, Inc. (HHC, Inc.) permission to verify the financial and insurance information provided by me, to determine eligibility. I understand it is my responsibility to keep HHC, Inc. informed of any changes in my family income and insurance status.

I authorize HHC, Inc. to release any information necessary to secure payment from my insurance company. I also authorize the use of this signature on all insurance submissions. I understand I am responsible for all charges regardless of insurance coverage. All co-pays and balances are due at the time of visit.

I authorize payment be made directly to HHC, Inc. by my insurance company for all services provided to me or my dependent.

The information provided is accurate and complete to the best of my knowledge and is only to be used for my treatment, billing, and/or for qualification for services to which I or my dependent may be eligible.

Print name: _____ Relationship: _____

_____ _____

Signature (Patient/Responsible Party/Legal Guardian) **Date**

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PATIENT CONSENT FORM to RELEASE INFORMATION

I give my consent and authorization to Hamakua Health Center, Inc. to release any information regarding my diagnostic/ medical treatment and financial status to the person(s) listed below.

Name: _____ Phone: _____

Relationship: _____ DOB: _____

Name: _____ Phone: _____

Relationship: _____ DOB: _____

Patient's Signature: _____ **Date:** _____

May we say that it is the Hamakua-Kohala Health when we contact you?
[ ] Yes [ ] No, then what is the best way to contact you? _____

May we leave appointment reminders on your voicemail at the phone number(s) indicated on the Patient Information form?
_____ Yes _____ No, how would you like to be notified? _____

*** If you are here for a **confidential** Family Planning visit, what is the best phone number where we can reach you? _____

HĀMĀKUA-KOHALA HEALTH

Caring for your 'ohana, Caring for you

HEALTH HISTORY FORM **DATE:** _____

Please help us by answering as many of the following questions as possible. This will help your Provider give you the best medical care.

NAME: _____ **DOB**: _____

Previous Provider(s): _____

Reason for changing Provider: _____

Do you have an Advanced Directive? (Living will, POLST) YES NO
List any medical problems that you have been diagnosed with:

Allergies	
Name of the Drug/Food	Reaction you had

Surgeries		
Year	Reason	Hospital

Other Hospitalizations:		
Year	Reason	Hospital

Current Medications (or attach a list)	Dose and Frequency taken

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Have you ever had a blood transfusion?			Yes	No
Family History				
Problem	Yes	No	Type of Problem	Relationship
Cancer				
Tuberculosis				
Asthma				
Diabetes				
Thyroid				
High Blood Pressure				
Heart Disease				
Genetic Disorders				
Mental Disorder				
Alcohol/Drug Abuse				
Other				

Health Habits					
Do you exercise?	None	Mild	Moderate	Vigorous	
Do you use tobacco (smoke, chew, vape)?	yes	What and how often?			No
Do you drink Alcohol?	yes	How much and how often?			No
Do you use recreational drugs?	yes	What and how often?			No
Do you drink beverages with caffeine?	yes	What and how often?			No

Mental Health				
Are you currently seeing a Counselor, Psychologist or Psychiatrist?	No	Yes	Currently seeing someone Who?	
Do you want to talk to someone about stress, depression, anxiety, or substance use?			Yes	No
Do you want to talk to someone about stop smoking?			Yes	No

WOMEN ONLY				
Age of first period:	Date of last period:	Monthly	Yes	No
Number of pregnancies:	Deliveries:	Terminations:		
Last PAP smear?	Last Mammogram?			
Current method of birth control:				
People age 50 and older: When was your last colonoscopy or stool test for colon cancer?				
Anything else you want us to know about you?				

Reviewed by: _____

HĀMĀKUA-KOHALA HEALTH

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HAMAKUA-KOHALA HEALTH-PATIENT CONTRACT

Welcome and thank you for choosing Hamakua-Kohala Health.

We, as a Patient-Centered Medical Home, are committed to providing you with the best medical care based on your health needs. Our hope is that we can form a partnership to keep your whole self as healthy as possible.

My care team and I will:
• Help you make the best decisions for your care.
• Provide care for any short-term illness, long-term chronic disease, and your over-all-well-being.
• Learn about you, your family, your health goals and preferences so that we can suggest personalized treatments that make sense for you.
• Be available to you after hours for your urgent care needs. After hours phone number 775-7204
• Help keep you up-to-date on all your vaccines and preventive screening tests.
• Communicate clearly with you so that you understand your condition(s) and all your options.
• Work with you to provide options that work best for your medical insurance plan.
• Notify you of your test results in a timely manner.
• Follow-up with you after you have been in emergency care or discharged from a hospital.
• Coordinate your care, as your health needs change.
• Help you arrange your transportation to and from your appointments.
• Always treat you with respect
• May share information within HHC's internal departments (medical, dental, behavior health, education and case management) so my family and I will receive the best integrative care.

My team and I look forward to working with you as your primary care provider in your patient-centered medical home.

Your care team: Patient name	Primary Care Provider:
Nurse or Medical Assistant and phone number:	Patient Registrar and phone number:
Referral Specialist and phone number:	Care Coordinator and phone number:

HĀMĀKUA-KOHALA HEALTH

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We trust you, as our patient, to:
• Know that you are a full partner with us in your care.
• Give feedback to help us optimize your care experience.
• Provide our office with a valid picture ID and insurance card. Be responsible for paying your co-pay at the time of visit.
• If you are uninsured, you may be eligible for a discount. Please see the front desk for patient assistance. Please provide documentation of income.
• Come to each visit with any updates on medications, dietary supplements or remedies that you are using, as well as any questions you might have.
• Notify use if you will be late for your appointment. If it will be more than 15 minutes, we may ask you to reschedule your appointment. If you need to cancel your appointment, please let us know 24 hours in advance.
• Let us know when you see other health care providers so we can help to coordinate the best care for you.
• Contact us after hours only if your issue cannot wait until the next workday.
• Schedule at least one office visit per year to perform health maintenance.
• Learn about your condition(s) and what you can do to stay as healthy as possible. ASK QUESTIONS when there is something that you do not understand.
• Follow the plan that we have agreed is best for your health and take medications as they are prescribed.
• Contact us if you do not receive your test result within one week.
• If possible, contact us before going to the emergency room or hospital so that we can communicate your medical history to the ER or hospital staff. Follow ER or hospital discharge instructions regarding any follow-up appointments with us.
• Please request your medication refills at least 3 working days before you need the refill.
• If you need transportation, either from the HKH van or from your insurance, please request it as soon as you know you will need it and at least 48 hours in advance.
• Treat other patients and staff with respect.
• Bring only service pets into the health center.

HĀMĀKUA-KOHALA HEALTH

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AUTHORIZATION TO ACCOMPANY AND PROVIDE CONSENT FOR A MINOR

This form is required by the State of Hawaii for another person to bring your child to Hamakua Health Center, Inc. in the event that you are unable to do so. Please print clearly.

Hamakua Health Center, Inc. is requesting that you fill out the attached form and have it signed before a HHC representative to allow another adult to bring your child (or children) to the clinic for an appointment, in the event that you are unable to do so. This is a state requirement that a minor cannot be seen without the parent or a legal guardian except for some specific circumstances. HHC will require the attached document signed by you before a HHC representative to give permission for another adult (18 years old and over) to bring your child. This document will be kept in our files and will be used to verify the identification of the adult who will be bringing your child. If there is more than one person you would like to designate, please provide their names and identification information, such as driver's license, state ID, or passport.

I, _____, give permission to the person (s) listed below to bring my minor child/children to Hamakua Health Center, Inc. if I am unable to bring my child for an appointment. I further authorize the person(s) to consent to treatment and administration of immunization(s).

Name of adult: _____ DOB: _____ (must be 18 and over)

Proof of ID (license, passport): No: _____ Expiration Date: _____

List other adults that are also allowed to bring your child/children:

Name: _____ DOB: _____ Proof of ID: _____

Name: _____ DOB: _____ Proof of ID: _____

Name: _____ DOB: _____ Proof of ID: _____

List the name(s) of your child/children:

Name of Child: _____ DOB: _____

Name of Child: _____ DOB: _____

Name of Child: _____ DOB: _____

Parent's Signature: _____ **Date:** _____

Witness (Print): _____

Signature: _____ Date: _____

HĀMĀKUA-KOHALA HEALTH

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

I hereby authorize the release of records/Verbal Exchange of Information

From:

Physician/Organization: _____ Dr._____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To:

HAMAKUA HEALTH CENTER, INC.

Address: 45-549 Plumeria Street City: Honokaa State: HI Zip: 96727

Phone: (808) 775-7204 Fax: (808) 930-2742

Information to be released:

☐ History & Physical Exam Dates: _____ ☐ Lab Reports Dates: _____

☐ Progress Notes Dates: _____ ☐ X-Ray Reports Dates: _____

☐ Other (please specify): _____ Dates: _____

I specifically authorize the release of information relating to:

[ ] Substance abuse (including alcohol/drug abuse)

[ ] Mental health (including psychotherapy notes)

[ ] HIV related information (AIDS related testing)

Purpose of Disclosure: [ ] Changing Physicians [ ] Legal [ ] School [ ] Other (specify):_____

This authorization is valid for one year after the dated signature. The authorization may be revoked at any time in writing and will be effective on the date notified except to the extent action taken has already been taken in reliance upon it.

Print Name: _____ Signature:_____ Date: _____

Relationship to Patient: _____

INTENTIONALLY LEFT BLANK

HĀMĀKUA-KOHALA HEALTH

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE and INFORMATION REGARDING THE HAWAII IMMUNIZATION REGISTRY

Hamakua Health Center, Inc. keeps record of health care services we provide you. You may ask to see and receive a copy of your health record. You may also ask to correct that record. Hamakua Health Center will not disclose your records to others, unless you direct us to do so, or unless the law authorizes or requires us to do so. To see your record or need more information about it please contact us at (808)775-7204.

The Notice of Privacy Practice describes in detail how your health information may be used and disclosed, and how you can access your information.

By signing below, I acknowledge that I have been presented with a copy of the Hamakua Health Center, Inc. Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information:

And I have received Hawaii Immunization Registry Information:

_____ _____

Signature of patient or authorized representative | Date

_____ _____

Printed name of person who signed on behalf of patient | Relationship to patient

I wish to place the following restrictions on disclosure of my health information:

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to the patient/representative and sign below

Presented on (date and time): _____

By (name and title): _____

INTENTIONALLY LEFT BLANK

HĀMĀKUA-KOHALA HEALTH

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Hamakua-Kohala Health Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Privacy Officer at the address listed below:

Alexis McDougall
IT Director
amcdoug@hamakua-health.org
Hamakua Health Center, Inc.
45-549 Plumeria St.
Honokaa, Hi 96727
Phone: 808-930-2735

- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. The complaint must be in writing. It must describe the subject matter of the complaint and the individuals or organization that you believe violated your privacy. Your complaint must be filed within 180 days of when the violation occurred. Complaints should be mailed to:

Region IX – San Francisco (American Samoa, Arizona, California, Guam, Hawaii, Nevada)
Michael Leoz, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: 800-368-1019
Fax: 800-368-1019
TDD: 800-537-7697

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again for this purpose.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research according to federal guidelines.

Comply with the law

We will share information about you as state or federal laws require it, including with the Department of Health and Human Services.

Respond to organ and tissue donation requests

If you are an organ donor, we can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military and national security

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

- This notice is effective as of July 1st 2020.
- This notice applies to all Hamakua Health Center, Inc. dba: Hamakua-Kohala Health entities and their locations

HAWAII IMMUNIZATION REGISTRY INFORMATION

INFORMATION CONTAINED IN THE REGISTRY

● Immunization information including but not limited to vaccine type, date of vaccine administration, vaccine administration site and route, lot number, expiration date,
patient's history of vaccine preventable diseases, contraindications, precautions, adverse reactions, and/or comments regarding vaccinations.
● Personal information including but not limited to an individual's first, middle, and last name, date of birth, gender, mailing address, phone number, parent/guardian
name, parent/guardian relationship to the individual, their contact information, and mother's maiden name.

CONFIDENTIALITY AND PRIVACY INFORMATION

All authorized users and the Department of Health Immunization Branch acknowledge that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (PL
104-191 and 45 CFR Parts 160 and 164, "Standards for Privacy of Individually Identifiable Health Information") governs the use and disclosure of individually identifiable
information by entities subject to the Privacy Rule. Although HIPAA standards for privacy were used as a guide to assist in the development of the Registry Confidentiality
and Privacy policies, the Registry and the Department of Health Immunization Branch are not "covered entities" under HIPAA. Providers, health plans and other covered
entities who are authorized users must comply with the HIPAA Privacy Rule.
Registry information will be entered by and available to authorized users for authorized purposes only. All authorized users will be required to safeguard the privacy of patient
participants by protecting confidential information in the Registry in accordance with the Hawaii Immunization Registry Confidentiality and Privacy Policy, the Hawaii
Immunization Registry Security Policy, as well as all applicable State and Federal Laws.

AUTHORIZED USERS

Authorized users of the Registry may include individuals and/or entities that require regular access to patient immunization and other individually identifiable health information
to provide immunization services to specific patients, maintain a computerized inventory of their public and private stock of vaccines, assess immunization status to determine
immunization rates, and/or ensure compliance with mandatory immunization requirements. All authorized users are required to sign a Hawaii Immunization Registry
Confidentiality and Security Statement indicating that they have received a copy of the Hawaii Immunization Registry Confidentiality and Privacy Policy and the Hawaii
Immunization Registry Security Policy, understand the terms, including penalties for violation of the policies, and agree to comply with the policies.
The Department of Health Immunization Branch is responsible for oversight of the Registry and therefore will be designated as an authorized user.

USES OF REGISTRY INFORMATION (AUTHORIZED PURPOSES)

Registry immunization data and other individually identifiable health information shall be utilized by authorized users for the purposes of:

● Consolidating, maintaining, and accessing computerized immunization records;
● Consolidating and maintaining vaccine inventory information;
● Determining the immunization history of individuals and delivering health care treatment accordingly;
● Generating notices for individuals who are due or overdue for immunizations and in the event of a vaccine recall;
● Staying abreast of the complex immunization schedule by utilizing registry-supplied immunization forecasting tools;
● Assessing the immunization rate of their patient population (or subsets thereof);
● Generating official immunization records (e.g. Student's Health Record);
● Ensuring compliance with mandatory immunization requirements;
● Recording the distribution of prophylactic and treatment medications administered or dispensed in preparation for and in response to a potentially catastrophic
disease threat;
● Complying with Hawaii Vaccines For Children and other State-provided vaccine programs' vaccine ordering and accountability policies and procedures; and
● Other purposes determined at the discretion of the Department of Health Immunization Branch.

Registry immunization data and other individually identifiable health information shall be utilized by the Department of Health Immunization Branch for the following public
health purposes including but not limited to:
● Ensuring compliance with mandatory immunization requirements;
● Performing Quality Improvement/Quality Assessment activities;
●Complying with Hawaii Vaccines For Children and other State-provided vaccine programs' vaccine ordering and accountability policies and procedures;
● Preventing and managing outbreaks of vaccine-preventable diseases and other public health emergencies;
● Producing immunization assessment reports to aid in the development of policies and strategies to improve public health;
● Managing and maintaining the Registry system; and
● Other purposes determined at the discretion of the Department of Health Immunization Branch.

AVAILABILITY OF IMMUNIZATION RECORD INFORMATION

An individual's immunization data and other individually identifiable health information in the Registry will be made available to the individual's immunization provider, the
Department of Health, and other Registry authorized users for authorized purposes only.

OPT-OUT

Individuals may choose not to include their or their child's immunization data in the Registry ("opt-out"). Individuals must opt-out in writing by completing a "Hawaii
Immunization Registry Opt-Out Form" which is available from the individual's immunization provider or the Department of Health Immunization Branch. The Registry will
retain only core demographic information necessary to identify the individual has chosen to opt-out of the Registry. This information is necessary to enable the Registry to
filter and refuse entry of immunization information for the individual. Core demographic data will be for Hawaii Department of Health use only and will be non-displaying to all
other Registry authorized users. An individual's decision not to authorize the inclusion of immunization data in the Registry will not affect whether or not they receive.
immunizations.

REVOCATION

An individual may revoke their decision to opt-out of the Hawaii Immunization Registry at any time. Revocations must be made in writing by completing a "Hawaii
Immunization Registry Reauthorization Form" obtained from the individual's immunization provider or the Department of Health Immunization Branch.

RIGHT TO INSPECT, COPY, CORRECT OR AMEND PERSONAL AND IMMUNIZATION INFORMATION

Individuals may inspect, copy, correct or amend their or their child's immunization record information via their or their child's immunization provider. For information on how to
inspect, copy, correct or amend your or your child's information, please speak with your doctor.

QUESTIONS?

If you have any questions about the Registry, please speak with your doctor or visit our website at:
http://health.hawaii.gov/docd/hawaii-immunization-registry/.