PROJECT VISION HAWAI'I
Hele for Health

Patient Approval for Release of Records by S&G lab to Project Vision Hawai'i (PVH), and PVH to necessary partners

*Note: There are no Fees to the Patient Signing this form

Returning Patient: Tested with us before? **YES** or **NO**

Patient Name:
_____

Date of Birth (DOB): _____ / _____ / _____
(Month/Date/Year)

Contact Phone: _____

Gender at Birth or Legal/Insurance gender (Please Circle): Male / Female

Mailing/Residential **address or hang out location**
_____

City, Zip Code_____

SSN: _____

Insurance Information:
Do you have insurance? YES or **NO**

If YES:
Insurance company: _____

Member ID #_____
(Provide copy of ID card with #)
Subscriber Name, Birthdate, relationship (if not self)
_____

Is patient of Native Hawaiian/Pacific Islander (NHPI) ancestry?
YES or **NO**

Release of Information to: Project Vision Hawai'i, who may share with necessary service providers including but not limited to PIC, HMIS and DOH

Method of Delivery:

- [X] Encrypted email to: Project Vision Hawai'i CEO and Medical Team at darrah@projectvisionhawaii.org
- [X] Call to (808)306-4406 Project Vision Hawai'i attn: Darrah Kauhane ED

I request that the following **information be shared between S&G Labs, Project Vision Hawai'i** and its **partner organizations** to include but not limited to **Partners in Care (PIC), HMIS, DOH and the host facility/program of this testing event**. I consent to release the following on the above-named patient: [X] **Copies of health, social service, and treatment reports** [X] **Other (describe): previous, current and future COVID-19 test results & treatments/care plans**

Signature: _____ Date: ____ /____ / ____

Print Name: _____ Relation to patient: _____

If signed by someone other than the patient or parent of a minor child, please provide documents to show authority to release of patient's protected health information.

I choose to be tested for:

X Personal Reasons ☐ Medical Procedure ☐ Travel ☐ Return to Work

My risk of exposure to COVID-19 in the last 14 days:

☐ Confirmed Exposure ☐ Unconfirmed Exposure ☐ No Exposure

Choose an option that best describes your symptoms:

☐ Severe Symptoms ☐ Mild Symptoms ☐ No Symptoms

Do any of the following health conditions apply to you? ☐ Yes ☐ No

Chronic kidney disease; COPD (Chronic Obstructive Pulmonary Disease); Immunocompromised state (weakened immune system) from solid organ transplant; Obesity (Body Mass Index (BMI) of 30 or higher); Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies; Sickle cell disease; Type 2 Diabetes Mellitus; Asthma (moderate to severe); Cerebrovascular disease (affects blood vessels and blood supply to the brain); Cystic fibrosis; Hypertension or High Blood Pressure; Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines (arthritis); Neurologic conditions, such as dementia; Liver disease; Pregnancy; Pulmonary fibrosis (having damaged or scarred lung tissues); Smoking; Thalassemia (a type of blood disorder); Type 1 Diabetes Mellitus

Legal consent for treatment:

I authorize, want, and give my consent for this and future COVID-19 testing affiliated with this health or treatment facility. I WILL quarantine until I receive my results, wear a mask, and take all reasonable prophylactic steps that may be recommended by my provider. If the test result is found to be positive, I/the patient will isolate for 10 days per the State Dept. of Health and the Centers for Disease Control (CDC). Any houseless individuals will be referred and transported to the Temporary Quarantine and Isolation Center (TQIC) or other facility being used as a temporary quarantine if TQIC is at capacity at the time.

Signature: _____ Date: _____

(updated-082020)