

## AUTHORIZED REPRESENTATIVE FORM

**ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED**

### PART A: MEMBER INFORMATION

Last Name	First Name	MI	
Address	City	State	ZIP Code
Email	Home Phone # (    )	Cell Phone # (    )	
HMSA Subscriber Number(s) (Located on your membership card)		Birth Date __ / __ / ____	

### PART B: REQUEST TYPE (Choose only one request per form)

**New Request** – This form is a request to assign a new authorized representative.

**Update an Existing Request** – This form is to modify (i.e., change the limitations on) a previously approved authorized representative.

**Revoke an Existing Request** – This form is to request termination of a previously approved authorized representative. Enter an effective date for the termination: \_\_ / \_\_ / \_\_\_\_.

### PART C: INFORMATION on AUTHORIZED REPRESENTATIVE(S)

**(All data fields must be completed)**

Name of Person or Organization	Relationship to Member	Drivers License # or last 4 digits of Social Security #
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### PART D: APPOINTMENT LIMITATIONS AND EXPIRATION

I understand that I have the right to limit the type of information that may be given to the authorized representative(s) named in Part C of this form. I further understand that by leaving this section blank, I am creating no limitation on the information that may be disclosed to the authorized representative(s).

Authorization Limitations: DO NOT DISCLOSE the type of information indicated below:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Claims & Payment            | <input type="checkbox"/> Eligibility & Enrollment | <input type="checkbox"/> Dues Payment & Billing       |
| <input type="checkbox"/> Referral & Preauthorization | <input type="checkbox"/> Medical Records          | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> HIV/AIDS                    | <input type="checkbox"/> Appeals                  | <input type="checkbox"/> Abortion/Family Planning     |
| <input type="checkbox"/> Other: _____                |   | <input type="checkbox"/> Alcohol/Substance Abuse      |

(Continued on next page)

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<b>Expiration</b>	<p>This appointment will expire five years from the date it was signed unless you specify a different date below:</p> <p> <input type="checkbox"/> One year  <input type="checkbox"/> Three years  <input type="checkbox"/> Until: ___/___/___ (must be less than five years)  <input type="checkbox"/> Event described here: _____  <span style="margin-left: 150px;">(must occur within five years)</span> </p>
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**PART E: YOUR INDIVIDUAL RIGHTS**

I understand that (**please read**):

- This appointment is based on my own need and HMSA does not condition treatment, payment, enrollment, or eligibility for benefits on receiving this appointment.
- I may revoke this appointment at any time by giving HMSA five business days written notice to the address indicated below. If I revoke this appointment, it will not affect any action HMSA took prior to receiving my written notice.
- Once my protected health information is disclosed to the person or organization I specified in Part C of this form, the information in their possession may no longer be protected by privacy laws.
- This appointment does not allow an authorized representative to request HMSA to release my information to others.
- HMSA will not treat someone as your authorized representative if we have reason to believe: 1) You may be subject to domestic violence, abuse, or neglect by the authorized representative; 2) Treating the person as your authorized representative could endanger you; or 3) In the exercise of professional judgment (for example, in a licensed professional's judgment) HMSA decides that it is not in your best interest to treat the person as your authorized representative.
- This request will expire at date specified in Part D of this form, upon revocation, or 18 months after my benefits coverage has terminated.
- I may request a copy of this signed form.
- If I have questions about this form, I may contact HMSA at (808) 948-6111 on Oahu.

**PART F: SIGNATURE**

I, (print member's name) \_\_\_\_\_, have had full opportunity to read and understand the contents of this form. I hereby release Hawaii Medical Service Association from all legal responsibility of liability that may arise from my appointment of the authorized representative(s). **I understand that, by signing this form, I am authorizing HMSA to allow my authorized representative(s) to act on my behalf as described above.**

**Member/Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

*If signed by other than the member or parent of minor child, please print your name below and indicate your relationship. Provide a copy of verification of your legal right (e.g., power of attorney documentation) to make this authorization.*

Authorized Representative Name: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

**INCOMPLETE FORMS WILL NOT BE PROCESSED  
ALL FIELDS ARE REQUIRED UNLESS OTHERWISE SPECIFIED**

Please complete, sign, and submit this form to:  
**HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860, (fax) 952-7580**