

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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Expiration	<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: _____ (must occur within five years) </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