AUTHORIZATION TO REQUEST OR RELEASE MEMBER INFORMATION

COMPLETE THIS FORM TO AUTHORIZE SHARING OF YOUR INFORMATION WITH A THIRD PARTY
ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

PART A: AUTHORIZING HMSA MEMBER INFORMATION
(ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED)

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)

☐ **Request to Have HMSA Receive Information** – This allows HMSA to obtain information from the person or organization indicated in Part C of this form.

☐ **Request to Have HMSA Send Information** – This allows HMSA to send copies of information to a person or organization you indicate in Part C of this form.

☐ **Revoke a Previous Authorization** – Checking this box indicates your request to terminate a previously approved authorization to request information from, or release information to, the person or organization you indicate in Part C of this form. Enter an effective date for the termination: _ _ /_ _ /_ _ _ _.

PART C: AUTHORIZED PERSON OR ORGANIZATION
(ALL data fields must be completed)

Last Name		First Name	MI
Address	City	State	ZIP Code
Organization Name	Telephone # ( )	Fax # ( )	

PART D: PURPOSE, SCOPE AND EXPIRATION
(All sections must be completed)

I hereby authorize the request and/or release of my medical information for the following purpose(s):

☐ Case Management/Appeals ☐ Enrollment

☐ Other (Please specify): _____

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Sensitive Information	By initialing, I agree to the release of the following information should it be contained in the description above of the information to be released: _____ HIV/AIDS or AIDS-related complex (ARC) (if initialed, form can be signed only by the member). _____ Behavioral or mental health services (if initialed, form can be signed only by the member or the member's legal guardian). _____ Alcohol and/or substance abuse treatment (if initialed, form can be signed only by the member or a legal guardian with a court order indicating authority to release and disclose substance abuse records). If I do not specifically agree, this information will not be disclosed.
Description	The information I permit to be requested or released is: ☐ Entire record (excluding sensitive information unless agreed to). ☐ Medical information for the specified date range only. _ _ /_ _ /_ _ _ _ to _ _ /_ _ /_ _ _ _ ☐ Other (please describe): _____
Expiration	This authorization will expire one year from the date on which it was signed or as specified below: ☐ Until final resolution of my appeal regarding services rendered on _ _ /_ _ /_ _ _ _ ☐ Until: _ _ /_ _ /_ _ _ _ (must be less than one year) ☐ Event described here: _____ (must occur within one year)

PART E: YOUR INDIVIDUAL RIGHTS

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

- This authorization is voluntary and is based on my own need and HMSA does not condition treatment, payment, enrollment, or eligibility for benefits on receiving this authorization.
- I may revoke this authorization at any time by giving HMSA five business days written notice to the address indicated below. If I revoke this authorization, it will not affect any action HMSA took prior to receiving my written notice to revoke.
- 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 authorization does not designate the person or organization listed in Part C to act as my authorized representative,
- I may request a copy of this signed form. (If HMSA initiates the request, a copy of the signed authorization form will be sent to me).
- If I have questions about this form, I may contact HMSA at (808) 948-6111 on Oahu.

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PART F: SIGNATURE

I, (print member's name) _____, have had full opportunity to read and consider the contents of this authorization. **I understand that, by signing this form, I am confirming my authorization to transmit my confidential member information as described in this form or to revoke a previous authorization.**

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

(00) 0135-10988 3:18 CS