



737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
Phone: (808) 941-4622
Toll-Free: (888) 941-4622

WRITTEN AUTHORIZATIONS

Date: _____

To: **PRIVACY OFFICER - HMAA**

From: _____
(Name of Member)

Address: _____

Member ID Number: _____

I) APPOINTMENT OF PERSONAL REPRESENTATIVE

I hereby appoint _____
(Name of Representative)

to serve as my personal representative regarding the following:

(Describe each purpose)

Member's Signature

Date

II) PROTECTED HEALTH INFORMATION

I hereby authorize HMAA to use and/or disclose Protected Health Information (PHI) about me to:

(Name of person or class of persons authorized to receive the information)

Address: _____

Phone Number: _____

The use or disclosure is for the following purpose(s):

(Describe each purpose, or purpose may be listed as "at the request of the individual authorized to receive my PHI.")

This authorization covers the following PHI (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Copies of Medical Records | <input type="checkbox"/> Insurance Applications |
| <input type="checkbox"/> Medical Claims | <input type="checkbox"/> Dental Claims |
| <input type="checkbox"/> Medical Reports | <input type="checkbox"/> Explanation of Benefits |
| <input type="checkbox"/> Other (please specify): _____ | |

This authorization covers PHI related to psychotherapy treatment records (check one):

- YES NO Initial Name to confirm selection: _____

This authorization will expire (check one):

- When my coverage with HMAA ends
 On other specific date (indicate date): _____

I understand and agree that:

- I have the right to refuse to sign this authorization.
- I do not have to sign this authorization in order to continue to receive treatment (except for research-related treatment).
- I do not have to sign this authorization in order to continue to receive coverage under my health plan.
- When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law.
- I have the right to revoke this authorization except to the extent that PHI has already been disclosed in reliance on this authorization. My revocation must be submitted IN WRITING to the Privacy Officer.

My signature, below, means that I understand and agree with the above statements.

Member or Personal Representative's Signature

Date

Personal Representative's Name (please print)

Relationship of Personal Representative to Member

PLEASE RETAIN A COPY FOR YOUR RECORDS.

Please return the completed form to:

**HMAA
Attn: Customer Service Center
737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
Or fax to: (808) 535-8353**