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

External Review HIPAA Authorization

Section A: I authorize the disclosure of my personal health information to the Persons/Entities as described in Section B below. I understand this authorization is voluntary and made to confirm my directions. I understand that once the information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations. I hereby give permission for the disclosure of my personal health information in the manner described below.

My Name: _____

Address: _____

Telephone: _____ Member Number: _____

Section B - Personal Health Information to Be Disclosed: I authorize the disclosure of the following personal health information:

All medical information of any sort relevant to the request for healthcare coverage which is the subject of my request for external review.

Your request will be deemed to include any information related to sexually transmitted disease, HIV/AIDS, alcohol or drug use or treatment, or mental health/psychology/psychiatry that may be within your above request, unless you specifically state your objection here:

_____

Person/Entity Authorized to Disclose: I authorize the person(s) and/or entity(ies) described below to disclose the personal health information described above:

All providers with medical records relevant to my request for external review ("Providers").

Person/Entity Authorized to Receive and Use: I authorize my Providers to disclose the non-public personal health information described above to the entity described below:

The Independent Review Organization ("IRO") assigned by the Insurance Commissioner of the State of Hawaii to conduct my external review.

Purpose of the Disclosure: The disclosure is being made for the following reason:

To conduct an external review of an adverse determination made by HMAA, pursuant to my request.

Right to Revoke: I may revoke this authorization in writing at any time. I understand my revocation will NOT affect any disclosures that were made by my Providers before actual receipt of notice of my written revocation. If I do not revoke it, this authorization will expire upon completion of the external review. To revoke this authorization, I must write to the Insurance Commissioner, Department of Commerce and Consumer Affairs, State of Hawaii, 335 Merchant St., Honolulu, Hawaii 96813.

SIGNATURE:

I, _____ , have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction. I understand that HMAA and my Providers will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, but that I must provide this authorization to be eligible for IRO external review by the Insurance Commissioner. I further understand that, by signing this form, I am confirming my authorization that the Providers identified above may disclose to the IRO assigned to conduct my external review the nonpublic personal health information described in this form.

Signature: _____ Date: _____

All data fields above must be completed for a valid authorization

If a personal representative on behalf of the individual signs this authorization, complete the following and attach a copy of legal authority if applicable (e.g., medical power of attorney, legal guardianship, etc.):

Personal Representative's Name: _____

Relationship to Individual: _____