

**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.

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Member ID: \_\_\_\_\_

**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 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: \_\_\_\_\_