HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

220 South King Street, Suite 1200
Honolulu, Hawaii 96813
Phone (808) 941-4622 / Toll-Free (888) 941-4622
CustomerService@hwmg.org / Fax (808) 535-8353

Written Authorization Form

Member Name:_____ Member ID: _____

Address: _____

I) Appointment of Personal Representative

I hereby appoint_____to serve as my personal representative
(Name of Representative)
regarding (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

Address:_____

Phone Number: _____

The use or disclosure is for the following purpose(s): ☐ At the request of the authorized individual

☐ Other – describe: _____

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

☐ ALL of my PHI, including psychotherapy treatment records

Specific uses only:

☐ Medical Records ☐ Insurance Applications ☐ Psychotherapy treatment records
☐ Medical Claims ☐ Dental Claims ☐ Other (specify): _____
☐ Medical Reports ☐ Explanation of Benefits

This authorization will expire: ☐ When my coverage ends ☐ On specific date:_____

My signature below means that I understand and agree:

- 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 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.

_____ _____
Member or Personal Representative's Signature Date

If not signed by member:

_____ _____
Personal Representative's Name (please print) Relationship of Representative to Member

Return this completed form to HWMG's Customer Service Center at the contact information shown at the top of this form. Please retain a copy for your records.