

## Authorization for Release of Protected Health Information (PHI)

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the Health Plan to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to the Health Plan. Revoking this authorization will not affect any action taken prior to receipt of your written request.

### Section A. Member Information: (individual whose information will be released)

<b>Group Name:</b>		<b>Member ID Number:</b>		
<b>Last Name:</b>		<b>First Name:</b>		<b>Middle Initial</b>
<b>Date of Birth:</b> <small>(Month/Day/Year)</small>		<b>Telephone Number:</b> <small>(including area code)</small>		
<b>Street Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>

### Section B. Authorization :

I understand that my health record is private and is known under the law as "Protected Health Information (PHI)".  
I authorize **Hawaii Mainland Administrators, LLC (HMA)** to release my PHI as described below.

### Section C. Recipient:

<b>Persons Name or Organization:</b>			
<b>Telephone Number:</b> <small>(including area code)</small>		<b>Fax Number:</b> <small>(if available)</small>	
<b>Street Address</b>		<b>City</b>	<b>State</b>
			<b>Zip</b>

### Section D. Reason and Description of the Information to be Released:

Reason for release:	
Check descriptions that apply	
<input type="checkbox"/>	Any information requested.*
<input type="checkbox"/>	Health (this includes medical, dental, pharmacy, vision, and flexible spending account information)*
<input type="checkbox"/>	Psychotherapy notes – Federal law requires a separate authorization to use or release psychotherapy notes. If you check this box, you must complete another form to authorize the release of any of PHI .
<input type="checkbox"/>	All information related to the provision of and payment for my health care benefits or services.*
<input type="checkbox"/>	Specific information as described on the line below:*
<small>Examples: The claim related to my service on (date); Appeal information related to my claim on (date)</small>	
<p><b>*NOTE:</b> Some State law requires that you give specific permission to release certain information.</p> <p>I understand that the above information to be disclosed under this authorization may contain information about HIV, AIDS diagnosis/treatment, mental health diagnosis/treatment, alcohol/drug diagnosis/treatment, developmental disability, and/or abuse, and I expressly authorize the disclosure of such information unless otherwise specifically indicated below:</p> <p><b>DO NOT disclose the following information:</b></p> <p> <input type="checkbox"/> Genetic Information                  <input type="checkbox"/> HIV / AIDS                  <input type="checkbox"/> Substance/Alcohol Abuse                  <input type="checkbox"/> Mental/Behavioral Health         </p>	

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<b>Section E. Expiration:</b>	
This authorization will expire (Check <u>ONLY ONE</u> box):	
<input type="checkbox"/>	When I revoke this authorization*
<input type="checkbox"/>	Upon the following date, event or condition*:
<p>Note: This authorization will terminate on the earliest of the events listed above or 180 days after termination of coverage.</p> <p>* Hawaii Mainland Administrators, LLC must be notified in writing of the event/condition to cancel or revoke this authorization.</p> <p>** Some State laws require that this Authorization to Release PHI automatically expire within a set timeframe, (example: Minnesota = 12 months, Montana = 24 months).</p>	
<b>Section F. Approval:</b>	
Please check all boxes to indicate you fully understand.	
<input type="checkbox"/>	I understand that this authorization to release information is voluntary and is not a condition of enrollment in this Health Plan, eligibility for benefits, or payment of claims.
<input type="checkbox"/>	I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.
<input type="checkbox"/>	I understand that if a request for copies of claims/ encounter information from the individual or company I have authorized above is received, then a reasonable fee may be charged (except where prohibited by law) to defray copying and mailing costs.
<input type="checkbox"/>	I understand I can receive a copy of this authorization form that I have signed by submitting a request in writing.
<input type="checkbox"/>	I understand that I may cancel or change this authorization at any time by providing notice in writing. I further understand that revoking this authorization will not have any affect on actions that took place before getting my request as received.
<input type="checkbox"/>	Any facsimile or photocopy of this authorization shall authorize Hawaii Mainland Administrators, LLC (HMA) to disclose the information requested herein. This authorization shall be effective as of the date of execution set forth below and remain in effect for a period stipulated, but not to exceed any time period set by State law.

<b>Member Signature:</b>		
By signing below, I authorize the release of my Protected Health Information as described above		
<b>Print Name:</b>	<b>Signature</b>	<b>Date</b>