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)

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

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:

Persons Name or Organization:			
Telephone Number: (including area code)	**Fax Number:** (if available)		
Street Address	**City**	**State**	**Zip**

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

Reason for release:	

Check descriptions that apply

- ☐ Any information requested.*
- ☐ Health (this includes medical, dental, pharmacy, vision, and flexible spending account information)*
- ☐ 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 .
- ☐ All information related to the provision of and payment for my health care benefits or services.*
- ☐ Specific information as described on the line below:*

  ____

  Examples: The claim related to my service on (date); Appeal information related to my claim on (date)
- ☐ **EUTF Supplemental Medical & Prescription Drug Plan** (Only)

  For Dependents: To release personal health information (PHI) or to have reimbursement checks issued directly to the plan subscriber, please initial below. This is not necessary for minors under the age of 18.

  Please Initial: ____________

***NOTE**: Some State law requires that you give specific permission to release certain information.

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:

DO NOT disclose the following information:

☐ **Genetic Information** ☐ **HIV / AIDS** ☐ **Substance/Alcohol Abuse** ☐ **Mental/Behavioral Health**

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Section E. Expiration:	
This authorization will expire (Check ONLY ONE box):	
☐	**When I revoke this authorization***
☐	**Upon the following date, event or condition*:**
	Note: This authorization will terminate on the earliest of the events listed above or 180 days after termination of coverage. * Hawaii Mainland Administrators, LLC **must** be notified in writing of the event/condition to cancel or revoke this authorization. ** Some State laws require that this Authorization to Release PHI automatically expire within a set timeframe, (example: Minnesota = 12 months, Montana = 24 months).

Section F. Approval:	
Please check all boxes to indicate you fully understand.	
☐	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.
☐	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.
☐	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.
☐	I understand I can receive a copy of this authorization form that I have signed by submitting a request in writing.
☐	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.
☐	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.

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