Hawaii HIPAA Authorization For Release Of Information

Use This Form To Allow the Release of Your Personal Health Information

Please keep a copy for your records

1. **Member Name** _____ **Phone** _____

   Address _____ **Member Number** _____

2. **List the personal health information you want UHA to give out**
   - For example: "The claims information related to my hip surgery in January 2017," or "All my health information in 2017," or "All the records related to my heart problems"
   - Use a separate form for release of psychotherapy notes
   - You may also exclude some health information
     For example: "all my health information except mental health records" or "all my medical records except x-ray films"

   _____

   _____

   ☐ Please check here if you authorize UHA to give out information related to any of the following, should it be contained within your medical record:
   - HIV, AIDS, or AIDS-related complex diagnosis or treatment
   - alcohol or drug use, diagnosis, or treatment
   - mental health counseling, diagnosis, or treatment

3. **Name and address of the person or organization (recipient) to which UHA should give your personal health information**
   For example: "My wife, Jane Doe" or "My grandson, John Doe" and the address
   Name: _____ Address: _____

4. **Reason for the disclosure**
   For example: "To answer questions about my claims" or "at the organization's request" or "for legal purposes"

   _____

5. **Right to take back ("revoke")**
   - I may revoke this authorization at any time by giving written notice to UHA. I understand my revocation will NOT affect any disclosures that occurred before UHA received notice of my written revocation and there may be other legal restrictions on my ability to revoke this authorization. For example, I understand that the revocation will not apply if this authorization was a condition for obtaining insurance coverage, when the law provides my insurer with the right to contest my policy or a claim under my policy.
   - If I do not revoke it, this authorization will expire on the following date or event: _____
     For example: "12/31/2019" or "When I terminate my UHA membership"
     - If a date or event is not specified, this authorization will expire one year from the date of signature below
   - To revoke this authorization, I will write a letter including the following:
     - My name, address, and member number
     - The names of the person or organization I no longer wish to receive my personal health information
     - My signature
   - I will mail or fax the letter to: UHA Customer Services, at the address or fax number listed above

6. **I authorize UHA to give out the protected health information** described above to the persons or organizations I named on this form. This authorization is voluntary. I understand that UHA will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed by law. I understand my protected health information may be re-disclosed by the recipient without my permission and may no longer be protected by law.

   Sign Your Name _____ Date _____

   If you are not the UHA member listed above you are signing as a personal representative. Please provide the following:
   - Attach the appropriate documentation (for example, Medical Power of Attorney, or court order)
   - Your phone number:_____