HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION
737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
Phone (808) 941-4622 / Toll-Free (888) 941-4622

WRITTEN AUTHORIZATIONS

Date: _____

To: **Privacy Officer – HMAA**

From: _____ Member ID: _____
(Name of Member)

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 to receive the information)

Address: _____

Phone Number: _____

The use or disclosure is for the following purpose(s): _____

_____
(Describe each purpose, or purpose may be listed as "at the request of the individual authorized to receive my PHI.")

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

☐ Medical Records ☐ Insurance Applications ☐ Other (specify): _____
☐ Medical Claims ☐ Dental Claims Psychotherapy treatment records:
☐ Medical Reports ☐ Explanation of Benefits _____ YES _____ NO (***initial*** one)

This authorization will expire: ☐ When my HMAA 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

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

Return this completed form to HMAA's Customer Service Center at the address shown at the top of this form, or you may fax it to **(808) 535-8353**. Please retain a copy for your records.