



900 Fort Street Mall, Suite 1900, Honolulu, HI 96813-3705 • Attention: Compliance
Email HDSCompliance@HawaiiDentalService.com • Fax (808)599-4808

AUTHORIZATION TO RELEASE MEMBER INFORMATION

Section A
By completing and signing this form, I hereby authorize Hawaii Dental Service (“HDS”) to disclose certain health information relating to: HDS Member’s Name: _____ HDS Member ID#: _____ Date of Birth: ____ / ____ / ____ Phone Number: (____) ____ - ____ (M M/ D D/ Y Y Y Y) Address: _____ City: _____ State: _____ Zip Code: _____ Reason for Release: _____ (If you do not wish to state the reason for release, please write, “At the request of the individual”)
Section B
I hereby authorize HDS to release the information specified in Section C to: Full Name: _____ Phone Number: (____) ____ - ____ Address: _____ City: _____ State: _____ Zip Code: _____
Section C
The information I authorize HDS to disclose consists of: (Check all appropriate boxes) <input type="checkbox"/> Dental Services Information <input type="checkbox"/> Payment Information <input type="checkbox"/> Eligibility Information <input type="checkbox"/> Identification Information <input type="checkbox"/> Other (Describe): _____ <input type="checkbox"/> All of the Above

Section D

This authorization will expire on the earlier of (Check one):

- The termination of my HDS dental plan
- / / (Enter desired expiration date)
(M M/D D/Y Y Y Y)

Section E

I understand that:

- After the information is disclosed, federal law might not protect it and the recipient might redisclose it.
- This authorization is voluntary and HDS may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I may revoke this authorization at any time by submitting a written request to HDS, Attn: Compliance Department, 900 Fort Street Mall, Suite 1900, Honolulu, HI 96813-3705. The revocation is only effective after it is received and processed by HDS. I understand that any use or disclosure prior to the revocation will not be affected by the revocation.
- I am entitled to receive a copy of this signed authorization form.

Section F

_____ / /
 HDS Member's Signature HDS Member's Name Date (M M/D D/Y Y Y Y)

_____ / /
 Personal Representative's Signature* Personal Representative's Name Date (MM/DD/YYYY)

*If a Personal Representative signs this form, that Representative hereby warrants that he or she has authority to sign on the basis of: _____

Please provide a copy of legal document(s) supporting the authority described above (e.g., Power of Attorney, Court Order).