

**AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION
BY THE Med-QUEST DIVISION (MQD)**

(1) _____ (2) _____
PRINT Name: Last, First, Middle Initial PRINT Legal Representative's Description of Authority

(3) I authorize the MQD to provide the following information: (Please check boxes below)

- Eligibility Insurance Information Payment History
- Enrollment Medical Claims Information Prior Authorization
- Other _____ Service Dates: ____/____/____ to ____/____/____

Please initial in the spaces provided if you authorize disclosures of the following **specially protected health information**:

_____ HIV/AIDS _____ Mental Health _____ Substance Abuse Treatment

about: (4) _____ (5) _____ and/or ____/____/____
PRINT NAME: Last, First, Middle Initial Social Security Number Birth Date (Month/Day/Year)

to: (6) _____ of _____
PRINT Name of Person/Agency Authorized to Receive Information Relationship to Applicant/Recipient (if any)

(7) _____ (8) _____
Mailing Address City State Zip Code Telephone

This information will be used to: (9) _____

This authorization is good for one year from the date you sign this form unless you tell us the following:

(10) Date: ____/____/____ OR Event: _____
Month Day Year

I understand that:

- a. I do not have to sign this form.
- b. I can cancel this form by writing to the above address, except for the information that was already disclosed.
- c. If I am an applicant and refuse to allow disclosure, this may affect my eligibility for coverage under the Hawaii State Medicaid program.
- d. If I am a recipient and refuse to allow disclosure of my protected health information, this may affect payment of my claims if the disclosure information is necessary to determine payment of my claims
- e. I can make a copy or check the information used or disclosed. If MQD knows who keeps the information, the MQD will provide me the name and address of the company or provider.
- f. I may have to pay a fee charged by the MQD to process the requested information.

(11) _____ Date: ____/____/____
Signature of Applicant / Recipient / Legal Representative ** Month Day Year

Mailing Address City State Zip Code

** The information released under this authorization may be subject to re-disclosures by the authorized person (6) above and the re-disclosure may not be protected under federal /state regulations.

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| FOR OFFICIAL USE ONLY: | UNIT: | | WKR: | | CID: | | Date: | |
|-------------------------------|--------------|--|-------------|--|-------------|--|--------------|--|