HIPAA AUTHORIZED REPRESENTATIVE FORM

This form is to APPOINT or REVOKE a family member, friend, or others who need access to your health information.

Please print legibly. Incomplete forms won't be processed.
All sections must be completed unless otherwise specified.

PART A: Member Information			
Last name	First name		MI
Address	City	State	ZIP code
Home phone no.	Work phone no.	Cell phone no.	
Birthdate (mm/dd/yyyy)	HMSA subscriber no(s). (from your HMSA membership card)		
Email			

PART B: Appointed Representative Information			
I want to (check one) ☐ appoint **or** ☐ revoke the individual below to contact HMSA on my behalf.			
Last name	First name		MI
Organization name			
Address	City	State	ZIP code
Home phone no.	Work phone no.	Cell phone no.	
Email			
Relationship to member	Last four digits of driver license no. or state ID no.	Birthdate (mm/dd/yyyy)	

PART C: Appointment Limitation

I understand that I have the right to limit the type of information that may be given to the appointed individual named in Part B of this form. I authorize the following information to be released:

☐ All my information (by checking this box, you authorize disclosure of all information listed below)

☐ Eligibility, enrollment, & billing	☐ Referrals & preauthorization	☐ Sexually transmitted diseases
☐ Claims	☐ Abortion/family planning	☐ HIV/AIDS
☐ Appeals	☐ Behavioral/mental health	☐ Other:
☐ Medical records	☐ Alcohol/substance abuse	

PART D: Date Your Appointment Expires (check one)

☐ No expiration (Please notify HMSA in writing when you're ready to revoke this authorization.)

☐ Please revoke this authorization on the following date: __ __ / __ __ / __ __ __ __ (mm/dd/yyyy)

☐ Please revoke this authorization when the following event occurs: _____

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PART E: Your Rights

I understand that (**please read**):

- This appointment authorizes the representative named above to access my health information, including health-related data, online accounts, and electronic data.
- This authorization doesn't allow the representative named above to make health care decisions on my behalf.
- This appointment doesn't allow an authorized representative to authorize other individuals.
- This appointment is based on my own need and HMSA doesn't condition treatment, payment, enrollment, or eligibility for benefits on receiving this appointment.
- Once my protected health information is disclosed, the information may no longer be protected by privacy laws.
- My information may be disclosed to my authorized representative using various communication methods including verbal communication, writing communication, and electronic communication.
- HMSA won't treat someone as my authorized representative if they have reason to believe: 1) I may be subject to domestic violence, abuse, or neglect by the authorized representative; 2) Treating the person as my authorized representative could endanger me; or 3) In the exercise of professional judgment (for example, in a licensed professional's judgment), HMSA decides that it's not in my best interest to treat the person as my authorized representative.
- I may revoke this appointment at any time by giving HMSA five business days written notice to the address indicated below. If I revoke this appointment, it won't affect any action HMSA took before receiving my written notice.
- I may request a copy of this signed form.

PART F: Signature

I, (print member's name) _____, have had full opportunity to read and understand the contents of this form. I hereby release Hawai'i Medical Service Association (HMSA) from all legal responsibility of liability that may arise from my appointment of the appointed representative. **I understand that, by signing this form, I am authorizing HMSA to disclose my health information to my appointed representative.**

Your Signature: _____ **Date:** _____

*If signed by other than the member, parent of minor child, or legal representative, please provide us the following information for identity verification so that we may update any future requests from you. Provide a copy of verification of your legal rights (e.g., child's birth certificate, power of attorney documentation) to make this authorization.

Last name	First name	MI	
Address	City	State	ZIP code
Home phone no.	Work phone no.	Cell phone no.	
Email			
Relationship to member	Last four digits of driver license no. or state ID no.	Birthdate (mm/dd/yyyy)	

☐ I've included a copy of verification of my legal rights (e.g., power of attorney, court document, etc.) to request this authorization. If you've previously submitted documentation, you don't need to resubmit it.

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860 Fax: (808) 952-7580