AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

NOTE: Please read through all sections carefully.
All fields marked with an asterisk (*) must be completed or this form cannot be processed.

SECTION I. MEMBER INFORMATION

*AlohaCare Member Name: ____

*AlohaCare ID: ______________________ *Date of Birth: ____/____/____ Phone: ____________________

SECTION II. MEMBER CONSENT

I agree that AlohaCare can give my protected health information to:

*Name: ____

*Relationship or Organization: ____

Address (if requesting to be mailed): ____

City, State, Zip: ____

Phone: ____________________________________ Fax (if applicable): ____________________________

SECTION III. PROTECTED HEALTH INFORMATION TO BE DISCLOSED

***The protected health information to be given out is (check ONE box only):**

- ☐ Entire medical information on record (see also Section IV. below for more boxes you may need to check)
- ☐ Medical information on record for specific date range only (insert dates): ___/___/___ to ___/___/___
- ☐ Other information related to: ____

SECTION IV. DISCLOSURE LIMITATIONS

I understand that I have the right to limit some types of information AlohaCare discloses. I give AlohaCare permission to give out (check ALL that apply):

- ☐ Information about treatment or counseling for substance abuse or dependency
- ☐ Information about psychiatric or mental health treatment
- ☐ Information about testing, treatment or counseling for HIV/AIDS or AIDS Related Complex (ARC)

For boxes you do <u>not</u> check, AlohaCare <u>will not</u> release information related to these conditions.

SECTION V. MINOR AUTHORIZATION FOR RELEASE OF PHI FOR SPECIALLY PROTECTED INFORMATION

ALL MEMBERS AGES 14-17 MUST READ THIS SECTION

For minors between the ages of 14-17, direct authorization from the individual is required for release of records related to family planning, pregnancy care, venereal disease and substance abuse (including counseling).

I am a minor between the age of 14 and 17 and consent to the release of my protected health information related to (if any of these boxes are checked, minor must sign and date below):

- ☐ Alcohol abuse or drug abuse (including counseling)
- ☐ Pregnancy care, family planning or treatment of venereal disease (including counseling)

For boxes you do <u>not</u> check, AlohaCare <u>will not</u> release information related to these conditions.

____ ____________________________

Signature of Minor aged 14-17 Date

SECTION VI. REASON(S) FOR DISCLOSURE

***This protected health information is being disclosed for the following purpose (specific reason or description):**

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SECTION VII. MEMBER ATTESTATION

This authorization is good until ___/___/___ or ______________________ (event), otherwise the authorization will expire 180 days from the date on which it was signed.

I understand that:

1. I may cancel this authorization at any time by writing to AlohaCare, Attention: Privacy Officer, 1357 Kapiolani Blvd., Suite 1250, Honolulu, Hawaii 96814. This cancellation will not have any effect on any information that has already been disclosed by AlohaCare before receiving my written cancellation notice.
2. My refusal to sign this authorization will not affect my enrollment with AlohaCare, but AlohaCare will not be able to release the requested information to the organization or person listed above without my signature.
3. I may be charged a cost-based fee for the processing of the requested information.

I expressly and voluntarily consent to disclosure of the information indicated above, and hereby release AlohaCare from all legal responsibility or liability that may arise from the release of this information. I understand that the information disclosed under this authorization may be disclosed by the recipient and may no longer be protected by federal and state law.

I hereby agree that a photocopy of this authorization may serve as an original, and do hereby waive any applicable requirements and provisions of 42 U.S.C. Section 4582, and the provisions of Hawaii Revised Statutes Chapters 325, 334, and 622 (Part V.) describing restrictions on the use and dissemination of the above information.

____ _________________________

*Signature of Member (or Legally Authorized Representative) *Date

If you are the legally authorized Personal Representative for the member, AlohaCare must have a copy of the legal documents and the following information must be provided:

Name: ____

Address: ____

Phone: (______) _______-_____________ Relationship to Enrollee: ______________________________