



INDIVIDUAL PLAN AUTHORIZATION FOR MEDICAL RECORDS

YOU MAY REFUSE TO SIGN THIS FORM

SECTION A: The individual(s) from whom this authorization is being requested

Name: _____
 (Subscriber's name)

Name(s): _____
 (List all dependents' names)

Address: _____

Telephone: _____ Email: _____

SECTION B: Please read the following statements carefully.

- **Purpose of this Authorization:** To provide HMSA your (and your minor dependents') protected health information so HMSA may determine your (and your dependents') eligibility for enrollment in HMSA's health plans and benefits under the health plans.
- **Effect of Declining this Authorization:** This authorization is a condition of enrollment in an HMSA health plan. If you decide not to sign this form, HMSA may decline to enroll you (and your minor dependents) in its health plans or decline to provide you (or your dependents) benefits.
- **Effect of Granting this Authorization:** This form permits disclosure of information to HMSA and its designee, which is subject to federal health information privacy laws. That means your (and your minor dependents') health information will continue to be protected by privacy laws.
- **Protected Health Information to be Used and Disclosed:** You authorize your (and your minor dependents') health care providers to disclose all of your (and your minor dependents') medical records to HMSA or its designee, including, but not limited to, records related to mental health, substance abuse, AIDS and HIV (subject to state and federal laws, including HRS §3311-5, the HIPAA Privacy Rule, and the Federal Substance Abuse Rule). This form does not authorize disclosure of psychotherapy notes.
- **Entities Authorized to Disclose:** You authorize your (and your minor dependents') current and former health care providers to disclose the protected health information described above, including, but not limited to, those health care providers listed on your health history form.
- **Entities Authorized to Receive and Use:** You authorize HMSA and its designee, Medwise Partners, Inc., to receive and use the protected health information described above for the purposes described above.

SECTION C: Expiration and Revocation

- **Expiration:** This authorization will expire on the later of the date the enrollment process is completed or your disenrollment from HMSA's health plan.
- **Right to Revoke:** I understand that I may revoke this form at any time by giving written notice of my revocation to the contact office listed below. I understand that revocation of this form will not affect any action HMSA takes in reliance on this form before receipt of my written notice of revocation. I also understand that if I revoke this form before HMSA has completed the enrollment process or before HMSA determines eligibility for benefits, HMSA may deem me (and my dependents) ineligible for enrollment or deny claims under the policy.

CONTACT OFFICE: HMSA ACCOUNT MANAGEMENT & SALES, ATTN: CSS, P.O. BOX 860, HONOLULU, HI 96808
TELEPHONE (808) 948-5555/OAHU 1 (800) 620-4672/NEIGHBOR ISLANDS FAX: (808) 948-6343
WEB SITE HMSA.COM

SIGNATURE - YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I, the subscriber (and any adult dependent named above), have read and considered the contents of this form. I understand that, by signing this form, I am authorizing the uses and disclosures of my (and my dependents') protected health information as described in this form.

Signature: _____ Date: _____
 (Subscriber's signature on behalf of subscriber and minor dependents)

Signature: _____ Date: _____
 (Spouse's or other adult dependent's signature)

If this form is signed by a personal representative on behalf of an individual, complete the following:

Personal Representative's Name: _____ Relationship to Individual: _____