PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

NOTE: Please read all Sections thoroughly.

ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

SECTION I. AUTHORIZING MEMBER INFORMATION

AlohaCare Member Name: _____

AlohaCare ID Number (*Located on ID card*): _____

Date of Birth: ___/___/___ Phone #: _____ Email Address: _____

AlohaCare Member Mailing Address: _____

SECTION II. REQUEST TYPE
(*CHOOSE ONLY ONE OPTION*)

☐ **Option 1:** Request to have AlohaCare send or disclose information. This allows AlohaCare to send copies of information or release information to a person or organization you indicate in Section III of this form.

☐ **Option 2:** Terminate an Existing Authorization. By checking this box, you indicate your request to terminate a current authorization to request information from, or release information to, the person or organization you indicate in Section III of this form. **Enter an effective date for the termination**: ___/___/___

SECTION III. MEMBER CONSENT: AUTHORIZED PERSON OR ORGANIZATION

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

Name: _____

Relationship to Member: _____

Address (if requesting to be mailed): _____

City, State, Zip Code: _____

Phone: _____ Fax (if applicable**):** _____

SECTION IV. PROTECTED HEALTH INFORMATION TO BE DISCLOSED

Please check the information you are authorizing to be requested or released:

☐ Entire medical information on record (see Section V. for more boxes you may need to initial)
☐ Medical information on record for specific date range only (insert dates): ___/___/___ to ___/___/___
☐ Only for services related to a specific health condition (state condition):_____
☐ Other (please describe): _____

SECTION V. DISCLOSURE LIMITATIONS

By initialing, I agree to release of the following information should it be included in the information stated in Section IV.

____ 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)

AlohaCare will not release information for items that you did not initial.

PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

NOTE: Please read all Sections thoroughly.

ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

SECTION VI. 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 and 17, 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 items 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)

AlohaCare will not release information for items that you did not check.

_____ _____

Signature of Minor aged 14-17 Date

SECTION VII. REASON(S) FOR DISCLOSURE

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

SECTION VIII. EXPIRATION DATE

This authorization will expire in one year from the date on which it was signed or until:

☐ __/__/__ (specific date must be less than one year)

☐ Until the end of health condition stated in Section IV

SECTION IX: MEMBER'S INDIVIDUAL RIGHTS AND ATTESTATION

I understand that:

1. I may cancel this authorization at any time by giving AlohaCare five (5) business days written notice 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.

PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

NOTE: Please read all Sections thoroughly.

ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

3. AlohaCare will not be able to release the requested information to the organization or person listed above without my signature.
4. This authorization does not designate the person or organization listed in Section III to act as my authorized representative.
5. I may be charged a reasonable fee for the duplication of my medical records.
6. 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 willingly consent to disclosure of the information specified above, and hereby release AlohaCare from all legal responsibility or liability that may arise from the release of this information.

_____ _____

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

If signed by anyone other than the member or parent of minor child, please print your name below and indicated your relationship. Please provide a copy of verification of your legal right (e.g., power of attorney documentation) to make this authorization.

Authorized Representative

Name:_____

Relationship to Member: _____

Phone: (_____) _____-_____