

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

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

(3) I authorize the following information for disclosure:

☐ Eligibility ☐ Insurance Information ☐ Payment History  
☐ Enrollment ☐ Medical Claims Information ☐ Prior Authorization  
☐ Other \_\_\_\_\_ Service Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

about: (4) \_\_\_\_\_ (5) \_\_\_\_\_ and \_\_\_\_/\_\_\_\_/\_\_\_\_  
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:

- I do not have to sign this form.
- I can cancel this form by writing to the above address, except for the information that was already disclosed.
- If I am an applicant and refuse to allow disclosure, this may affect my eligibility for coverage under the Hawaii State Medicaid program.
- 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
- 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.
- 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

\* Any changes or alterations to the content of this page will invalidate this form.

\*\* The information released under this authorization may be subject to re-disclosures by the authorized person (5) above and the re-disclosure may not be protected under federal /state regulations.

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