Clear Form

STATE OF HAWAII
Department of Human Services

Med-QUEST Division
P. O. Box 700190
Kapolei, HI 96709-0190

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:

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