STATE OF HAWAII
Department of Human Services

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

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

TO THE Med-QUEST DIVISION (MQD)

(1) ______________________________ PRINT Name: Last, First, Middle Initial

(2) ______________________________ PRINT Legal Representative's Description of Authority

I authorize (3) ______________________________ to provide the following information:
PRINT Name of Person/Agency Authorized to Disclose Information

(Please check boxes below):

- ☐ Medical Records
- ☐ Insurance Information
- ☐ Payment History
- ☐ Enrollment
- ☐ Medical Claims Information
- ☐ Other ______________________ Service Dates: ______ / ______ / ______ to _____ / ______ /______

Please initial in the spaces provided if you authorize disclosures of the following **specially protected health information**:

__________ HIV/AIDS __________ Mental Health __________ Substance Abuse Treatment

about: (4) ______________________________ (5) ____________________ and _____ / _____ / _____
PRINT NAME: Last, First, Middle Initial — Social Security Number — Birth Date (Month/Day/Year)

To the Hawaii Dept of Human Services, Med-QUEST division. Contact Name : ______________________

(6) ______________________ ____________ ______ ________ (7) ____________________
Mailing Address — City — State — Zip — 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:

(8) Date ________ / ________ / _________ OR Event: ______________________________
Month — Day — Year

I understand that:

a. If I do not sign this form, Med-QUEST will not get the information you requested.
b. I can cancel this form by writing to the above named **(3) above**, except for the information that was already disclosed.
c. If I am applying for Medical assistance and refuse to allow disclosure, it 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, it may affect payment of my claims if the disclosure is necessary to determine the payment of my claims.
e. I can receive a copy or check the information used or disclosed.
f. I may have to pay a fee to process the requested information.

(9) ______________________________ ____________/__________/_________
(Signature of Applicant / Recipient / Legal Representative) — Date: Month — Day — Year

______________________________ ____________ ________ __________
Mailing Address — City — State — Zip Code

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