HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION
220 South King Street, Suite 1200
Honolulu, Hawaii 96813
Phone (808) 941-4622 / Toll-Free (888) 941-4622
CustomerService@hmaa.com / Fax (808) 535-8353

Written Authorization Form

Return a completed form to HMAA's Customer Service Center at the contact information shown at the top of this form. Please retain a copy for your records.

Member Name _____ Member ID _____

Address _____

I) Appointment of Personal Representative

I hereby appoint _____ to serve as my personal representative
(Name of Representative)

regarding (describe each purpose): _____

Member's Signature _____ Date _____

II) Protected Health Information (PHI)

I hereby authorize HMAA to use and/or disclose Protected Health Information (PHI) about me to:

Name of person or class of persons authorized _____ Phone Number _____

Address _____

The use or disclosure is for the following purpose(s): ☐ At the request of the authorized individual

☐ Other – describe: _____

This authorization covers the following PHI (check all that apply):

☐ **ALL of my PHI,** including psychotherapy treatment and reproductive health care (RHC)* records.

Specific uses only:

☐ Medical Records	☐ Insurance Applications	☐ Psychotherapy treatment records
☐ Medical Claims	☐ Dental Claims	☐ Reproductive health care records*
☐ Medical Reports	☐ Explanation of Benefits	☐ Other (specify): _____

*If PHI includes reproductive health records, you must also submit a **Reproductive Healthcare (RHC) attestation.**

This authorization will expire: ☐ When my coverage ends ☐ On specific date: _____

My signature below means that I understand and agree:

- I have the right to refuse to sign this authorization.
- I do not have to sign this authorization in order to continue to receive treatment (except research-related treatment).
- I do not have to sign this authorization in order to continue to receive coverage under my health plan.
- When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law.
- I have the right to revoke this authorization except to the extent that PHI has already been disclosed in reliance on this authorization. My revocation must be submitted **in writing** to the Privacy Officer.

Member or Personal Representative's Signature _____ Date _____

If not signed by member:

Personal Representative's Name (please print) _____ Relationship of Representative to Member _____