900 Fort Street Mall, Suite 1900, Honolulu, HI 96813-3705 • Attention: Compliance
Email HDSCompliance@HawaiiDentalService.com • Fax (808)599-4808

# AUTHORIZATION TO RELEASE MEMBER INFORMATION

## Section A

By completing and signing this form, I hereby authorize Hawaii Dental Service ("HDS") to disclose certain health information relating to:

HDS Member's Name:_____ HDS Member ID#:_____

Date of Birth:__/__/____ (M M/ D D/ Y Y Y Y) Phone Number:(  ) -

Address:_____

City:_____ State:_____ Zip Code:_____

Reason for Release:_____
(If you do not wish to state the reason for release, please write, "At the request of the individual")

## Section B

I hereby authorize HDS to release the information specified in Section C to:

Full Name:_____ Phone Number:(  ) -

Address:_____

City:_____ State:_____ Zip Code:_____

## Section C

The information I authorize HDS to disclose consists of:
(Check all appropriate boxes)

☐ Dental Services Information

☐ Payment Information

☐ Eligibility Information

☐ Identification Information

☐ Other (Describe):_____

☐ All of the Above

**Section D**

This authorization will expire on the earlier of (Check one):

☐ The termination of my HDS dental plan

☐ __/__/____ (Enter desired expiration date)
(M M/ D D/ Y Y Y Y)

**Section E**

I understand that:

- After the information is disclosed, federal law might not protect it and the recipient might redisclose it.
- This authorization is voluntary and HDS may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I may revoke this authorization at any time by submitting a written request to HDS, Attn: Compliance Department, 900 Fort Street Mall, Suite 1900, Honolulu, HI 96813-3705. The revocation is only effective after it is received and processed by HDS. I understand that any use or disclosure prior to the revocation will not be affected by the revocation.
- I am entitled to receive a copy of this signed authorization form.

**Section F**

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|---|---|---|
| | | / / |
| HDS Member's Signature | HDS Member's Name | Date (M M/ D D/ Y Y Y Y) |
| | | / / |
| Personal Representative's Signature* | Personal Representative's Name | Date (MM/DD/YYYY) |

*If a Personal Representative signs this form, that Representative hereby warrants that he or she has authority to sign on the basis of:_____

**Please provide a copy of legal document(s) supporting the authority described above (e.g., Power of Attorney, Court Order).**