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:_____/_____/__________ Phone Number:(   )   -
(M M/ D D/ Y Y Y Y)

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)
(MM/DD/YYYY)

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

______________________	______________________	___/___/______
HDS Member's Signature	HDS Member's Name	Date (MM/DD/YYYY)
______________________	______________________	___/___/______
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).