AUTHORIZED REPRESENTATIVE FORM

hmsa®
An Independent Licensee of the Blue Cross and Blue Shield Association

COMPLETE THIS FORM TO AUTHORIZE FAMILY AND FRIENDS TO CONTACT HMSA ON YOUR BEHALF
ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

PART A: MEMBER INFORMATION

Last Name	First Name		MI
Address	City	State	ZIP Code
Email	Home Phone # ( )	Cell Phone # ( )	
HMSA Subscriber Number(s) (Located on your membership card)		Birth Date _ _ /_ _ /_ _ _ _	

PART B: REQUEST TYPE (Choose only one request per form)

☐ **New Request** – This form is a request to assign a new authorized representative.

☐ **Update an Existing Request** – This form is to modify (i.e., change the limitations on) a previously approved authorized representative.

☐ **Revoke an Existing Request** – This form is to request termination of a previously approved authorized representative. Enter an effective date for the termination: _ _ /_ _ /_ _ _ _.

PART C: INFORMATION on AUTHORIZED REPRESENTATIVE(S) (All data fields must be completed)

Name of Person or Organization	Relationship to Member	Drivers License # or last 4 digits of Social Security #
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PART D: APPOINTMENT LIMITATIONS AND EXPIRATION

I understand that I have the right to limit the type of information that may be given to the authorized representative(s) named in Part C of this form. I further understand that by leaving this section blank, I am creating no limitation on the information that may be disclosed to the authorized representative(s).

Authorization Limitations: DO NOT DISCLOSE the type of information indicated below:

☐ Claims & Payment
☐ Referral & Preauthorization
☐ HIV/AIDS
☐ Other:_____

☐ Eligibility & Enrollment
☐ Medical Records
☐ Appeals

☐ Dues Payment & Billing
☐ Sexually Transmitted Disease
☐ Abortion/Family Planning
☐ Alcohol/Substance Abuse

(Continued on next page)

Expiration	This appointment will expire five years from the date it was signed unless you specify a different date below: ☐ One year ☐ Three years ☐ Until: _ _ /_ _/_ _ _ _ (must be less than five years) ☐ Event described here: _____ (must occur within five years)

PART E: YOUR INDIVIDUAL RIGHTS

I understand that (**please read**):

- This appointment is based on my own need and HMSA does not condition treatment, payment, enrollment, or eligibility for benefits on receiving this appointment.
- I may revoke this appointment at any time by giving HMSA five business days written notice to the address indicated below. If I revoke this appointment, it will not affect any action HMSA took prior to receiving my written notice.
- Once my protected health information is disclosed to the person or organization I specified in Part C of this form, the information in their possession may no longer be protected by privacy laws.
- This appointment does not allow an authorized representative to request HMSA to release my information to others.
- HMSA will not treat someone as your authorized representative if we have reason to believe: 1) You may be subject to domestic violence, abuse, or neglect by the authorized representative; 2) Treating the person as your authorized representative could endanger you; or 3) In the exercise of professional judgment (for example, in a licensed professional's judgment) HMSA decides that it is not in your best interest to treat the person as your authorized representative.
- This request will expire at date specified in Part D of this form, upon revocation, or 18 months after my benefits coverage has terminated.
- I may request a copy of this signed form.
- If I have questions about this form, I may contact HMSA at (808) 948-6111 on Oahu.

PART F: SIGNATURE

I, (print member's name) _____, have had full opportunity to read and understand the contents of this form. I hereby release Hawaii Medical Service Association from all legal responsibility of liability that may arise from my appointment of the authorized representative(s). **I understand that, by signing this form, I am authorizing HMSA to allow my authorized representative(s) to act on my behalf as described above.**

Member/Authorized Signature: _____ **Date:** _ _ /_ _/_ _ _ _

If signed by other than the member or parent of minor child, please print your name below and indicate your relationship. Provide a copy of verification of your legal right (e.g., power of attorney documentation) to make this authorization.

Authorized Representative Name: _____

Relationship to Member: _____

INCOMPLETE FORMS WILL NOT BE PROCESSED
ALL FIELDS ARE REQUIRED UNLESS OTHERWISE SPECIFIED

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860, (fax) 952-7580