AUTHORIZATION TO REQUEST AND/OR RELEASE
MEMBER INFORMATION FORM

Please complete and sign this form to authorize the Hawaii Laborers Health and Welfare Trust Fund to request and/or release your information that you specify for your stated purpose. Please return this form to the following address: Hawaii Laborers Health and Welfare Trust Fund Office, HIPAA Privacy Officer, 1440 Kapiolani Blvd., Ste 800, Honolulu, Hawaii 96814.

PART A: MEMBER AUTHORIZING REQUEST AND/OR RELEASE

First Name	**MI**	**Last Name**	
Member ID Number:	**Date of Birth**		**Telephone Number for Contact Purposes:**

PART B: YOUR RIGHTS UNDER FEDERAL LAW

You have the right to authorize the confidential member information held by the Hawaii Laborers Health and Welfare Trust Fund be released to and/or received by persons or organizations you identify. The person or organization you identify below may not be subject to federal health information privacy law. If this is the case, they may further release your confidential member information and federal health information laws may no longer protect it. Upon request, you are entitled to receive a copy of this signed form.

NO CONDITIONS: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

YOUR RIGHT TO REVOKE: You may revoke this authorization at any time by giving written notice to HAWAII LABORERS HEALTH AND WELFARE TRUST FUND. Cancellation of this authorization will not affect any action we took prior to receiving your written notification. **Please contact HAWAII LABORERS HEALTH AND WELFARE TRUST FUND'S Member Services Department at (808) 441-8700 or toll free at (888) 520-8078 for more information if you desire to cancel this authorization.**

PART C: AUTHORIZATION TO REQUEST AND/OR RELEASE YOUR MEMBER INFORMATION

1. Please state the purpose of this authorization:

☐ To release information at my request

☐ Other – for the following purposes (please specify and describe in detail):_____

_____

2. I hereby authorize a third party to do the following on my behalf:

☐ To make a request for me

☐ To obtain my information

☐ Other (please specify and describe in detail): _____

_____

_____

3. Select 1 or more of the boxes below to inform us what information is covered by this authorization.

☐ Enrollment	☐ Claims	☐ Case Management/ Appeals
☐ Mental Health/ Substance Abuse/ Family Planning/ HIV/AIDS/STDs	☐ Other (please specify)	☐ All

AUTHORIZATION TO REQUEST AND/OR RELEASE
MEMBER INFORMATION FORM

4. I understand that this authorization applies to my HAWAII LABORERS HEALTH AND WELFARE TRUST FUND plan I have, or have had, and includes any future HAWAII LABORERS HEALTH AND WELFARE TRUST FUND plans I enroll in while this authorization is in effect.

5. I understand that my authorization will remain in effect for the length of time specified below (select one of the following):

   a. ☐ Until I cease to be a HAWAII LABORERS HEALTH AND WELFARE TRUST FUND member

   b. ☐ End Date:____/_____/_____

   c. ☐ Completion of the following activity: Please describe._____

6. **I authorize HAWAII LABORERS HEALTH AND WELFARE TRUST FUND to request my information from and/or release my information to:**

Name of Person/ organization:		
Address Line 1:		
Address Line 2:	Apt No.:	
City:	State:	Zip Code
Telephone:	Fax:	
Name of Person/ organization:		
Address Line 1:		
Address Line 2:	Apt No.:	
City:	State:	Zip Code
Telephone:	Fax:	

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the request and release of my confidential member information, as described in this form.

Member Signature: _____ **Date:** _____

If this request is by a personal representative on behalf of the member, please provide the documentation authorizing your representation of the member and the following information:

Personal representative's name: _____

Relationship to member: _____

HAWAII LABORERS HEALTH AND WELFARE TRUST FUND USE ONLY:

Date Received:	Received By:
Date Revoked:	Received By: