Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

HIPAA Authorization Form for Release of Protected Health Information

I, _____, hereby authorize the use or disclosure of protected health information as described in this authorization.

1. Specific person or organization authorized to provide the information:
   Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
   _____

2. Specific person or organization authorized to receive and use the information (*name, relation, address and phone).*
   _____

3. Specific description of the information to be used or disclosed (*e.g. disclosure of all enrollment information, including who is enrolled in plans).*
   _____

4. Purpose of the request: (*Check one*)
   - ☐ At the request of the individual signing this form.
   - ☐ Other: _____

5. Right to Revoke: I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the Privacy Officer (in writing) at the address at the bottom of this form. I understand that such a revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

6. I understand the federal Health Insurance Portability and Accountability Act (HIPAA) does not protect the privacy of information if disclosed by an individual authorized to receive the information.

7. I understand that I am entitled to receive a copy of this authorization and the information described on this form.

8. I understand that this authorization will expire as indicated below:
   - ☐ One year from the date of this authorization.
   - ☐ Other: _____

9. Enrollment or eligibility for benefits is not conditioned upon receipt of this authorization form.

_____ _____
Signature of Individual Date

or

_____ _____
Signature of Personal Representative Date

If a Personal Representative executes this form the Representative warrants that he or she has authority to sign the authorization form on the basis of:

- ☐ A signed Personal Representative Form
- ☐ Other: _____

This authorization reflects the requirements of 45CFR § 164.508 (8-14-02) and updated for HIPAA Omnibus (9-23-13).

Once completed, please return this form to the:
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121 Honolulu, HI 96805-2121
Telephone: 808-586-7390 or 1-800-295-0089

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