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 or

_________________________
Date

___________________________________________
Signature of Personal Representative or

_________________________
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:
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700, Honolulu, HI 96813
Telephone: 808-586-7390 or 1-800-295-0089

Revised 07/30/21