

**AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION  
TO THE MED-QUEST DIVISION (MQD)**

I, (1) \_\_\_\_\_ (if legal representative,  
Print Name of – **Circle One:** ( Applicant, Recipient, Legal Representative )

(2) \_\_\_\_\_), authorize (3) \_\_\_\_\_  
( Description of Legal Representative’s Authority ) ( Individual, Agency, Organization )

to provide the following specific information: (4) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

about: (5) \_\_\_\_\_ or \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
( Name of Applicant/Recipient ) Social Security Number Date of birth

to: (6) \_\_\_\_\_ of the Dept. of Human Services, Med-QUEST Division, whose  
( Name of Authorized Person to receive information )

mailing address is: \_\_\_\_\_  
Mailing Address City State Zip code Telephone

The information will be used to: (7) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- I understand that:
- a. I may **refuse** to sign this authorization.
  - b. I can **cancel** this authorization before it ends, except information already disclosed, by writing to:  
Med-Quest Division - Administration  
P.O. Box 700190  
Kapolei, HI 96709 – 0190
  - c. If I am an applicant, my refusal to authorize disclosure may affect my eligibility for coverage under the Hawaii State Medicaid program.
  - d. If I am a recipient, my refusal to authorize disclosure of protected health information will not affect my eligibility for coverage under the Hawaii State Medicaid program. But it **may** affect payment of my claim if disclosure of this information is necessary to determine payment of the claim.
  - e. **\*\*** I understand the information released under this authorization may be subject to re-disclosure by the person authorized to receive this information and the re-disclosure **may not** be protected under federal/state regulations

This authorization is good until (8) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ or \_\_\_\_\_ (or for  
90 days, whichever is sooner) Date Event

(9) \_\_\_\_\_  
SIGNATURE of ( Applicant / Recipient / Legal representative ) \*\* Date

\_\_\_\_\_  
Print Mailing Address City State Zip code