Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

YOUR INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:

Persons/Organizations Providing the Information	Persons/Organizations to Receive the Information
Hawaii Employer-Union Health Benefit	
Trust Fund (EUTF)	

Description of the Information to be Released (Provide a detailed description of the specific information to be released)

Description of Each Purpose for the Use or Release of the Information (Provide a detailed description of the activity for which the information will be used)

Will the person/organization receive money for the release of this information?
☐ Yes ☒ No

This authorization for release of the above information to the above named persons/organizations will expire on the following date or event: _________ *(date)* ____ *(event)*

I understand:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I have the right to revoke this authorization by sending a written notice stopping this authorization to EUTF at BOX 2121 H,H. The authorization will stop on the date my request is received, but the revocation will not apply to any actions the health plan took before receiving the revocation.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand that I cannot revoke this authorization if 1) the EUTF has taken action in reliance on the authorization, or if 2) the authorization was obtained as a condition of obtaining insurance coverage.
- I understand that I am signing this authorization voluntarily and that treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization, except that the health plan may condition enrollment in the plan or eligibility for benefits on this authorization if I am not yet enrolled in the plan, the purpose of this authorization is to allow the plan to obtain information needed to make an eligibility, enrollment, underwriting or risk determination, and psychotherapy notes are not requested. In this situation, if I refuse to sign this authorization, I may be denied enrollment in the plan or eligibility for health benefits.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.

Signature:	Date: