STATE OF HAWAII
Department of Human Services

Med-QUEST Division
P. O. Box 700190
Kapolei, HI 96709-0190

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION
BY THE Med-QUEST DIVISION (MQD)

(1) _____ (2) _____
PRINT Name: Last, First, Middle Initial — PRINT Legal Representative's Description of Authority

I authorize the MQD to provide the following information (Please check boxes below):

☐ Eligibility ☐ Insurance Information ☐ Payment History
☐ Enrollment ☐ Medical Claims Information ☐ Prior Authorization
☐ Other _____ Service Dates: ____ / ____ / ____ to ____ / ____ / ____

Please initial in the spaces provided if you authorize disclosures of the following **specially protected health information**:

_____ HIV/AIDS _____ Mental Health _____ Substance Abuse Treatment

about: (4) _____ (5) _____ and ____ / ____ / ____
PRINT NAME: Last, First, Middle Initial — Social Security Number — Birth Date (Month/Day/Year)

To: (6) _____ Of _____
PRINT Name of Person/Agency Authorized to Receive information — Relationship to Applicant/Recipient (if any)

(7) _____ _____ _____ _____ (8) _____
Mailing Address — City — State — Zip Code — Telephone

This information will be used to: (9) _____

This authorization is good for one year from the date you sign this form unless you tell us the following:

(10) Date _____ / _____ / _____ OR Event : _____
Month Day Year

I understand that:

a. I do not have to sign this form.
b. I can cancel this form by writing to the above address, except for the information that was already disclosed.
c. If I am an applicant and refuse to allow disclosure, this may affect my eligibility for coverage under the Hawaii State Medicaid program.
d. If I am a recipient and refuse to allow disclosure of my protected health information, this may affect payment of my claims if the disclosure information is necessary to determine payment of my claims
e. I can make a copy or check the information used or disclosed. If MQD knows who keeps the information, the MQD will provide me the name and address of the company or provider.
f. I may have to pay a fee charged by the MQD to process the requested information.

(11) _____ Date: _____ / _____ / _____
(Signature of Applicant / Recipient / Legal Representative) ** — Month Day Year

_____ _____ _____ _____
Mailing Address — City — State — Zip Code

** The information released under this authorization may be subject to re-disclosures by the authorized person (5) above and the re-disclosure may not be protected under federal /state regulations.

FOR OFFICIAL USE ONLY:	UNIT:		WKR:		CID:		Date:	

INSTRUCTIONS

DHS 1123 (Revised 10/05)

Authorization to Disclose Confidential Information **by** the Med-QUEST Division

Purpose:

1. To allow Med-QUEST Division to secure authorization to disclose information to the applicant, recipient or legal representative or to a third party authorized to receive specific confidential information.

Specifics:

1. Applicable full name must be stated.
2. If legal representative, describe the type of legal appointment. (i.e. lawyer, court order, legal guardian, or legal parent etc.) Attach a copy of the legal authorization with DHS 1123.
3. Describe information requested by using the check boxes provided, be as specific as possible.
4. Name of Applicant/Recipient.
5. Social Security Number, and Date of Birth.
6. Name of party or agency authorized to receive the information specified. Relationship to applicant/recipient, if any.
7. Mailing address of the party authorized to received the information.
8. Phone number of the party authorized to received the information.
9. The reason the information is wanted and how it is to be used. The applicant, client or legal representative is **Not** required to fill out this section.
10. Expiration date or event of this authorization, whichever is shorter. Not to exceed 1 calendar year from date of authorization. Example: date of authorization 10/21/2005, expiration date 10/20/2006.
11. Signature, date and address of applicant, recipient or legal representative identified in item (1).

MQD staff:

1. Verify the identity of the client/legal representative.
2. Inform the authorized requestor that the copy of the requested information is available at reasonable cost-based fee plus postage.
3. Date stamp the authorization form.
4. Review client case record for restrictions before making disclosures. release the specific information Authorized only, redact any information not related to the request or the client (including information of other clients in the same case file).
5. If requested information **IS** available: (Refer to MQD Division Policy & Procedures 1.B.5.1.b.vi.A)
   - Disclose requested information within 10 working days from date of receipt of authorization.
   - forward original DHS 1123 to MQD Administration via courier mail
6. If requested information is **NOT** available in your branch,

   Fax completed DHS 1123 and DHS 8021 to MQD Administration within 5 working days, forward original DHS 1123 via courier mail.

   MQD **Administration will identify the location of requested information** and fax DHS 1123 to appropriate Branch.

   Branch must disclose information within 30 days of original receipt of request and fax DHS 8021 specifying date requested information was disclosed.

   If multiple Branches are involved, Then MQD **Administration** will act as central point. Branches that contain requested info will fax or forward to MQD Administration.
7. File a duplicate copy in client case record and route original copy of authorization form DHS 1123 to MQD Administration & store for 6 years.

*** Do not release any information not specified in the authorization.**