

# HMSA



Blue Cross  
Blue Shield  
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association



## PERMISSION TO SHARE MEDICAL INFORMATION

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ HMSA Member Number: \_\_\_\_\_

**CONSENT:** I give permission to HMSA, its *He Hāpai Pono* program manager, and the following health care providers to share information related to my pregnancy (**include name and telephone of each provider**):

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

I understand that my records may contain protected health information requiring special permission from me to be shared. I give permission for the following information to be shared (**initial each item if okay to share**):

- \_\_\_\_\_ Mental Health diagnosis and/or treatment
- \_\_\_\_\_ Substance Abuse diagnosis and/or treatment
- \_\_\_\_\_ HIV/AIDS or other sexually transmitted diseases diagnosis and/or treatment

I give permission for the above health care providers to share the following verbal and written health information:

- My entire record, **OR**
- Only the following information (**initial each item if okay to share**)
 

_____ Substance Abuse Evaluation	_____ Treatment Plan
_____ Treatment Recommendations	_____ Name of New Treatment Provider
_____ Expected Length of Treatment	_____ Treatment Progress Report
_____ Attendance Records Only	_____ Diagnosis/Assessment

**I consent to receiving *He Hapai Pono* program information via telephone or mail at the telephone number and address listed above.**

**PURPOSE:** By signing this form, I give permission to *He Hāpai Pono* and the above health care providers to share my medical information for any or all of the following purposes:

- To permit case management
- To identify potential pregnancy problems
- To provide wellness information
- To coordinate special treatment if needed

**CANCELLATION:** I understand that I may withdraw my permission at any time, except to the extent that the program or person which is to make this disclosure has acted in reliance on it, by giving notice to HMSA's *He Hāpai Pono* program manager at:

HE HAPAI PONO  
PAN AM BUILDING  
1600 KAPIOLANI BLVD STE 920  
HONOLULU, HI 96814-9954

Phone: 952-4454 on Oahu or 1-888-400-2776 toll-free from Neighbor Islands

I understand that cancellation of this permission will not affect any action *He Hāpai Pono* and my health care providers took before they received my notice.

**EXPIRATION DATE:** If not previously cancelled, this permission will expire nine months following the date below.

A file copy is equivalent to the original of this form.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**If this consent is signed by an authorized representative of the individual, please provide:**

\_\_\_\_\_  
Authorized Representative Name

\_\_\_\_\_  
Relationship to Individual

**NOTICE TO RECIPIENT OF SUBSTANCE ABUSE INFORMATION:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless disclosure is expressly permitted by the written authorization of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient