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 (Applicant/Recipient/Legal Representative) — PRINT: Legal Representative's Authority

(3) 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/or ______ / ______ / ______
PRINT NAME: Last, First, Middle Initial — Social Security Number — Birth Date (Month/Day/Year)

To: (6) The Lien Resolution Group Of ______________________________
PRINT Name of Person/Agency Authorized to Receive information — Relationship to Applicant/Recipient (if any)

(7) 55 Old Nyack Turnpike Rd., Ste 311 Nanuet NY 10954 (8) 952-476-7322
Mailing Address — City — State — Zip Code — Telephone

This information will be used to: (9) substantiate Medicaid's lien relating to a lawsuit

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 (6) above and the re-disclosure may not be protected under federal /state regulations.

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