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AUTHORIZATION TO RELEASE AND/OR RESTRICT MEMBER INFORMATION

*Release Information to: _____ HDS Member ID No. (if applicable) _____

Address: _____ Phone No: _____

Reason for Release: _____

***Please initial one of the statements below:**

_____ I hereby authorize Hawaii Dental Service to provide the above-named individual or company with all dental data and information they may request, as listed below, concerning me and/or my dependents.

_____ I hereby refuse Hawaii Dental Service to provide the above-named individual or company with dental data and information concerning me and/or my dependents.

PROTECTED HEALTH INFORMATION (PHI)

***Check all PHI that applies to the above statement:**

_____	All PHI that HDS has about me	_____	All PHI that HDS has about my dependents
_____	Name	_____	Dental Coverage _____ Other
_____	Member Identification Number	_____	Dentist Name If selected other, list here:
_____	Social Security Number	_____	Dentist Address _____
_____	Birth Date	_____	Dentist Fees _____
_____	Address	_____	Patient Charges _____
_____	Phone Number	_____	Dates of Service _____
_____	Group Number	_____	Reports of Dental Services _____
_____	Group Name	_____	Listing of Procedure Codes _____

*Member Name (please print): _____ *HDS Member ID No: _____

*Signature of Member: _____ Date: _____ Phone No: _____

I hereby authorize the release of information on the following dependents:

Dependent Name (please print): _____ HDS Member ID No: _____

Dependent Name (please print): _____ HDS Member ID No: _____

Dependent Name (please print): _____ HDS Member ID No: _____

HDS Use Only:

Request received from: Name: _____ Department: _____ Date: _____

LED updated by: Name: _____ Department: _____ Date: _____

(original to be placed in Quality Management files)