Hawaii Life & Disability Insurance Guaranty Association
1003 Bishop Street
Suite 2030
Honolulu, HI 96813

tel. (808)744-4919
www.hilifega.org

POLICYHOLDER AUTHORIZATION TO RELEASE INFORMATION

Policyholder name _____ Policy number _____
PLEASE PRINT

AUTHORIZATION: I authorize Hawaii Life & Disability Insurance Guaranty Association, hereinafter referred to as "HILIFEGA," to release written and/or verbal information about my insurance policy and claim, including my medical care and treatment and other non-medical information as deemed necessary by HILIFEGA, to the following individuals:

Name (please print)	Relationship	Telephone number

REVOCATION: I understand that I have the right to revoke this authorization. Such revocation must be sent in writing to HILIFEGA at 1003 Bishop Street, Suite 2030, Honolulu, HI 96813 or penntreatyaloha@hilifega.org and will become effective when received by HILIFEGA. I understand that even if I revoke this authorization, HILIFEGA will, and will be permitted to disclose information as required or permitted by law and as permitted by other authorizations I have given HILIFEGA, and in accordance with its notices of information practices.

DISCLOSURE AND REDISCLOSURE: HILIFEGA cannot guarantee that the individuals I have authorized will not disclose or re-disclose my personal information. If disclosed under this authorization, protected health information is no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) and state and federal laws.

PERIOD OF VALIDITY: This authorization shall be valid from the date signed for either **six (6) months, or as long as my policy remains in force,** whichever is later, unless revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

Signed _____ Date _____

Name (please print) _____

If this authorization is signed by a personal or legal representative of the applicant/insured, complete the following:

Personal/legal representative's name _____

Relationship to applicant/insured Other _____

Basis for representation (POA, guardian, etc.) Other _____
PLEASE ATTACH COPY OF LEGAL DOCUMENT

Please submit your completed form using one of the options below. For further assistance please contact us at

Email: penntreatyaloha@hilifega.org
Mail: 1003 Bishop Street
Suite 2030
Honolulu, HI 96813