STATE OF HAWAII
Department of Human Services

Med-QUEST Division

Request to Restrict Disclosure of Protected Health Information

I, _____ (if legal
Print name of - **Circle One:** (Applicant, Recipient, Legal Representative)

representative _____) request the Med-QUEST
(Description of Legal Representative's Authority)

Division to **restrict** the use or disclosure of the following Protected health information maintained for or by MQD:

_____

_____

_____

_____

My mailing address is: _____
Mailing Address

_____ _____ _____
City State Zip Code

Signature: _____

(for MQD use only)

Date ____/____/____

MQD has made a determination of your request and shall:

- ☐ Restrict the disclosure of information
- ☐ Not restrict the disclosure of information for the following reason(s)
  - ☐ The information is required for authorized purposes of the HI Medicaid program
  - ☐ The information must be disclosed as required by applicable laws
  - ☐ Other: _____

If you require more information, please contact:

MQD Administration
P.O. Box 700190
Kapolei, HI 96709-0190