



## **NOTICE OF NON-DISCLOSURE OF PRIMARY MEDICAL CARE AND SERVICES FOR MINORS**

Pursuant to §577D-2, HRS, licensed health care practitioners may provide primary medical care and services to a minor who consents to the primary medical care and services if the physician reasonably believes that: (1) the minor understands the significant benefits and risks of the proposed primary medical care and services and can communicate an informed consent; (2) the primary medical care and services are for the minor's benefit; and (3) the minor is a "minor without support", as defined in §577D-1, HRS.

Please complete the form if you are a licensed health care practitioner rendering medical care and services to a minor and believe that disclosure of any information related to the treatment provided should not be disclosed to the minor's parent(s)/legal guardian because the information may endanger the minor.

This form should be completed in its entirety prior to submitting the claim. 'Ohana Health Plan has 14 days to make the necessary changes to comply with the request for confidentiality.

**PLEASE COMPLETE, SIGN AND SEND THIS NOTICE AND THE NON-DISCLOSURE AGREEMENT TO 'OHANA HEALTH PLAN:**

'Ohana Health Plan  
Attn: Compliance Department  
820 Mililani Street, Suite 200  
Honolulu, HI 96813  
Or  
Fax: (877) 297-3112

<b>PART A: MEMBER INFORMATION</b>			
Last Name	First Name		MI
Address	City	State	Zip Code
Email	Home Phone No.	Cell Phone No.	
'Ohana Member ID Number		Birthdate (mm/dd/yyyy)	
<b>PART B: REQUEST TYPE (Choose only ONE request per form)</b>			
<input type="checkbox"/> New Request <input type="checkbox"/> Update Existing Request <input type="checkbox"/> Cancel Request as of _____ <span style="float: right;">(Date: mm/dd/yyyy)</span>			
<b>PART C: ATTESTATION OF ENDANGERMENT</b>			
<p>Federal privacy laws provides the right to request confidential communications to avoid endangerment.</p> <p>BY INITIALING THIS SECTION, I ATTEST THAT FAILURE TO COMMUNICATE THE MINOR'S PROTECTED HEALTH INFORMATION THROUGH ALTERNATIVE MEANS OR TO AN ALTERNATE LOCATION COULD ENDANGER THE MINOR.</p> <p>(Initial here) _____</p>			
<b>PART D: ALTERNATE MAILING ADDRESS</b>			
<p>Minors between the ages of 14 and 17 may ask that communications related to medical care and services be sent to an address other than the mailing address that 'Ohana Health Plan has on file.</p> <p><input type="checkbox"/> Mail all member communications to this address:</p>			
Address	City	State	ZIP Code
<b>Licensed Health Care Practitioner's Signature REQUIRED:</b>			
Signature:		Date:	
Printed Name and Credentials:		Agency or name of business:	
Phone number:		NPI #:	