AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

This form is to be used for consent of disclosure of health information for purposes of further medical care claims resolution, coordinating care for dependent, insurance eligibility or benefits or other specified reason.

Authorization will grant those named permission to speak to the CCHP Grievance and Appeal Committee on your behalf.
If you do not wish to grant another person permission to represent you, you do not need to complete this form.

Completed form should be submitted to CCHP by mail, fax or email.

Mail to: Chorus Community Health Plans
PO Box 1997
Milwaukee, WI 53201-1997

Fax: 414-266-4195
Email: CCHP-Appeals@chorushealthplans.org

MEMBER:

Name of member:	
Birth Date:	
Member Number/SSN:	
Street Address:	
City, State, Zip:	
Phone Number:	

AUTHORIZES:

Name of Health Care Provider/Plan/Other:	
Street Address:	
City, State, Zip:	

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other:	
Street Address:	
City, State, Zip:	

INFORMATION TO BE RELEASED:
The following is a specific description of the health information I authorize to be used and/or disclosed.

In compliance with WI Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

- ☐ Mental Health
- ☐ Developmental Disabilities
- ☐ Alcohol and/or Drug Abuse
- ☐ HIV Test Results
- ☐ Other (Please Specify) _____

For the following date(s): From _____ To _____

PURPOSE FOR NEED OF DISCLOSURE: (check applicable categories)

☐ Further Medical Care ☐ Claims Resolution ☐ Coordinating Care for Dependent
☐ Insurance Eligibility/Benefits ☐ Other (Specify):

_____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses that must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Customer Services. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Customer Services. I am aware that my withdrawal will not be effective until received by Children's Community Health Plan and will not be effective regarding the uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until:
☐ Date _____ ☐ Termination of my health insurance

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REPRESENTATIVE: _____
DATE: _____

(If signed by other than patient, state relationship and authority to do so.)