PO Box 1997, MS 6280
Milwaukee, WI 53201-1997
Toll-free: 1-800-428-8010
chorushealthplans.org

Personal Health Information Release Form

As a Chorus Community Health Plans member, you can use this Personal Health Information (PHI) Authorization Form when you want to give another person or organization permission to access your health information. For example, a PHI Authorization Form is used if you want someone other than yourself to regularly discuss your health claims with us. **This form must be filled out completely**.

SECTION 1 – PERSON AUTHORIZING USE AND/OR DISCLOSURE

Name (First, M.I, Last) _____

Member Name and ID Number (on Forward Health ID card) _____

Street Address _____

City _____ **State** _____ **Zip** _____

Date of Birth (MM/DD/YYYY) _____

Preferred Phone Number _____ **May we leave a message?** _____

SECTION 2 – THE USE AND/OR DISCLOSURE THE PERSON IS AUTHORIZING

I hereby authorize Chorus Community Health Plans to disclosure the following protected health information (ex: medical records):

_____

This authorization will be in effect as of the date signed or _____ and will terminate as of _____ or on the members 18th birthday if the member is a minor.

For the following specific purpose(s). Please check if applicable:

- ☐ Payment of claims
- ☐ Coordination of Benefits
- ☐ Insurance Eligibility / Benefits
- ☐ Prior Authorization
- ☐ Complaint
- ☐ Coordinating care for dependent / spouse:
- ☐ Legal Representation/ Proceedings
- ☐ Other: _____

Disclosure Protected Health Information to:

Name of Person / Organization _____

Street Address _____

City _____ **State** _____ **Zip** _____

Phone Number (AREA CODE) XXX-XXXX _____

Fax Number _____

Please continue on the next page

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SECTION 3 – SIGNATURE

1. I authorize Chorus Community Health Plans, and their affiliated health plans (collectively, "CCHP") to share my protected health information ("PHI") as described above.

2. I understand that my PHI may contain information about communicable diseases (including HIV and AIDS), behavioral or mental health services, sexually transmitted diseases, genetic testing, and information about treatment for alcohol and drug abuse. By checking this box, I indicate that I do not want these types of information released with the rest of my PHI: ☐

3. **Right to Refuse to Sign this Authorization**: I understand that I am under no obligation to sign this form and that CCHP may not condition treatment, payment or eligibility for health care benefits on my decision to sign this authorization.

4. **Right to Withdraw this Authorization**: I understand written notification is necessary to revoke this authorization. To obtain information on how to revoke my authorization, I must contact the CCHP Plan Administrator (contact Customer Service at the address below). I am aware that my revocation will not be effective until received by CCHP. I understand that my revocation will have no effect on disclosures made before CCHP received my revocation.

5. **Redisclosure Notice:** I understand once CCHP discloses my information based on this authorization, this authorization may no longer be protected by federal and state private standards and that my health information may be re-disclosed without obtaining my authorization.

6. This authorization will expire 24 months from the date signed, unless I specify an earlier date or event here: _____

7. I have had an opportunity to review this authorization form. I understand the content of this authorization form. By signing this authorization form, I am confirming that it accurately reflects my wishes. I am entitled to keep a copy of this form for my records.

_____

Your signature / Your Personal Representative's signature and relationship to the member

_____ _____

Printed Name **Date Signed**

If a Personal Representative has signed this form, please attach appropriate documentation verifying legal authority, such as Guardianship or Power of Attorney Documents, if applicable.

Please return this form to:
Chorus Community Health Plans
Attn: Customer Service
PO Box 56099
Madison, WI 53705

Internal Reference: BCP Member Form - Personal Health Information Release Form (Rev. 03/29/2021).