AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

MEMBER:

______________________________	______________________________
Name of Member	Birth Date/Member Number/SSN
______________________________	______________________ ( ) __________
Street Address	City, State, Zip, Phone

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. ________

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

☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol & or/Drug Abuse

☐ HIV Test Results ☐ Other (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 Chorus Community Health Plans 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

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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.)