Chorus Community Health Plans
PO Box 1997 - MS 6280 | Milwaukee, WI53201-1997
Toll-free: 1-844-201-4672 | chorushealthplans.org

Authorization for Disclosure

As a CCHP member, you can use this Authorization for Disclosure Form when you want to give another person or organization permission to access your health information. For example, an Authorization for Disclosure Form is used if you want someone other than yourself to regularly discuss your health claims with us (such as an insurance agent). **This form must be filled out completely.**

Section 1 – Member Information (the person authorizing use and/or disclosure)

NAME (First, M.I. Last) _____ **MEMBER ID NUMBER** (on member ID card) _____

STREET ADDRESS **CITY** **STATE** **ZIP**

_____ **DATE OF BIRTH** (MM/DD/YYYY)

PREFERRED PHONE NUMBER

Section 2 – Authorization and Release

I hereby authorize:

NAME OF PERSON OR ORGANIZATION) _____

STREET ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

PHONE NUBMER (XXX) XXX-XXXX _____ **FAX NUMBER** (if applicable) _____

Please release my protect health information to:

NAME OF PERSON OR ORGANIZATION) _____

STREET ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

Chorus Community Health Plans
PO Box 1997 - MS 6280 | Milwaukee, WI53201-1997
Toll-free: 1-844-201-4672 | chorushealthplans.org

Section 3 – 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 statues, 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:

For the following dates:

From: _____ To: _____

Section 4 – Purpose for need of disclosure

Check all applicable categories:

- ☐ Further medical care
- ☐ Claims resolution
- ☐ Coordinating care of 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 not longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorizations.

Section 5 – Your rights with respect to this authorization

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 Service.

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.

Chorus Community Health Plans
PO Box 1997 - MS 6280 | Milwaukee, WI 53201-1997
Toll-free: 1-844-201-4672 | chorushealthplans.org

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 abov e 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 Service. 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.

Section 6 – Expiration Date and Signature

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.

_____ _____

Patient Signature / Legal Representatives Date

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