MY CHOICE WISCONSIN, INC.
Attn: Health Information Clerk
1617 Sherman Avenue, Madison, WI 53704
(Phone) 608-245-3109 (Fax) 608-245-3107

MY CHOICE WISCONSIN AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

Member information:

Name of Individual / Previous Names _____ Birth Date _____

Street Address _____ City, State, Zip _____

Phone _____ Email _____

Please select any of the following that apply:

☐ **Authorize MY CHOICE WISCONSIN to release my Protected Health Information (PHI) to the following Person or Organization:**

Name _____

Address _____

Phone of Person or Program Requesting Information _____ Fax Number _____

Email _____

☐ **Authorize:** _____
Name of Person or Organization Releasing Information
to release my Protected Health Information (PHI) to MY CHOICE WISCONSIN to the attention of:

Name of Care Manager or RN and Care Management Unit _____

Address _____

Phone for Care Management Unit _____ Fax Number _____

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The following specific information from my records may be released:
Please specify type of information and dates (e.g. records from September 1, 2015 to present)

_____

This authorization includes disclosure of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS of AIDS-related illness and/or HIV test results with the following exception(s):

_____

_____

The purpose of this authorization is:
Please specify. "At the Request of the Individual" is sufficient if the Member named above is initiating this Authorization

_____

_____

REDISCLOSURE NOTICE: I understand that information released may be used or disclosed by the recipient as allowed by law.

EXPIRATION DATE: This Authorization is good until _____
Date

~ OR ~

Until the occurrence of the following event (e.g., disenrollment from My Choice Wisconsin):

_____

Note if no date or specific event is indicated,
then this Authorization shall remain in effect for 12 months from the date of signature below.

By signing this Authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE: _____
Member / Legal Decision Maker *(If signed by other than member, state relationship)*

DATE:_____ ☐ **Check this box if no records are needed at this time.**
(form will be kept on file and records sent upon request)

I understand that this Authorization is voluntary and 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 or eligibility on my decision to sign this authorization. I understand that I may revoke this Authorization by providing a written notice of revocation to My Choice Wisconsin's Privacy Office at the address listed below. The revocation will be effective immediately upon My Choice Wisconsin's receipt of my written notice, except that the revocation will not have any effect on any action taken by My Choice Wisconsin in reliance on this Authorization before it received my written notice of revocation. I acknowledge and consent that any information may be disclosed to providers, insurance companies, and other health care entities for treatment, payment or operations of health care business purposes.

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I may contact My Choice Wisconsin's Privacy Officer by mail at:

My Choice Wisconsin
Attn: Privacy Officer
10201 W. Innovation Drive, Suite 100
Wauwatosa, WI 53226

By telephone at 414-287-7612 or by fax at 414-287-7704
By email at dlfamcprivacyofficer@mychoicefamilycare.org