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

MY CHOICE WISCONSIN HEALTH PLAN AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION
For use with all non-medical providers, family members, friends, etc.

Member Name: _____ **Date of Birth:** _____

Release of Information

I authorize the use, release and/or exchange of the information listed below between MY CHOICE WISCONSIN HEALTH PLAN INC. and the person(s)/organization(s) designated below for the purpose of coordinating my ongoing care, treatment and personal needs. I understand I am under no obligation to sign this form and that MY CHOICE WISCONSIN HEALTH PLAN INC. may not condition treatment or payment on my decision to sign this authorization. I understand the information used, released or exchanged as a result of this authorization may no longer be protected by federal privacy laws and may be further used, released or exchanged by persons or organizations receiving it without obtaining my authorization. Please use additional forms if necessary.

Check the boxes of information that may be disclosed

Primary Authorized Individual	**Financial Information**	**Health & Care Planning Information**	**Exceptions to Health Information**
Name:			
Relationship:			
Phone Number:			
Secondary Authorized Individual			
Name:			
Relationship:			
Phone Number:			
Authorized Individual			
Name:			
Relationship:			
Phone Number:			
Authorized Individual			
Name:			
Relationship:			
Phone Number:			
Authorized Individual			
Name:			
Relationship:			
Phone Number:			

See reverse side

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

_____ _____

Signature of member or guardian/legal representative – specify relationship Date

_____

Print name of guardian/legal representative, if applicable

This authorization shall be effective until (Check one):

____ Disenrollment OR

____ Date or other event:_____***unless revoked by the member sooner than the date or event listed.***

Your Rights with Respect to This Authorization: Please initial.

- ✓ **_____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 in accordance with My Choice Wisconsin Health Plan Inc.'s .policies and procedures. For information on the procedures to inspect or obtain copies of my health information, I may contact My Choice Wisconsin Health Plan Inc.'s Health Information Clerk at 1-608-245-3109.

- ✓ **_____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 neither My Choice Wisconsin Health Plan Inc., nor any person or organization listed above may not condition treatment or payment on whether I sign this authorization.

- ✓ **_____ Redisclosure Notice -** I understand that information released as allowed under this authorization may be used or disclosed by the recipient as allowed by law.

- ✓ **_____Right to Revoke This Authorization -** I understand that I may revoke this authorization in writing at any time. To obtain information on how to revoke this authorization or to receive a copy of my revocation, I may contact My Choice Wisconsin Health Plan Inc.'s Health Information Clerk at 1-608-245-3109. I am aware that my revocation of this authorization will not impact any disclosures that the person(s) and or organization(s) listed above have already made in reliance on this authorization.