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

A photocopy of this authorization is as valid as the original.
A separate authorization must be used for psychotherapy notes, as defined by HIPAA.

1. By signing this authorization form I authorize the use and/or release of my protected health information as described below. I understand that I am under no obligation to sign this form and that MY CHOICE WISCONSIN HEALTH PLAN INC. may not condition treatment or payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand the information used or released as a result of this authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organization receiving it without obtaining my authorization.

Name of Member _____ Date of Birth _____

Street Address _____ City, State, Zip _____

2. Authorize:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip Code _____

3. To Release Protected Health Information To:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip Code _____

4. Description of Health Information I Authorize to be Used and/or Disclosed.

___ Medical History, Examination, Reports
___ Treatment or Tests
___ Immunizations
___ X-ray Reports
___ Laboratory Reports
___ Entire Records
___ Other (Specify): _____
___ Surgical Reports
___ Hospital Records Including Reports
___ Allergy Records
___ Prescriptions
___ Consultations
___ General Assessments
___ Vocational Assessments
___ Behavior Plans
___ Residential Care Plans
___ School IEPs
___ Waiver ISPs

Federal and state laws require special permission to release certain information. Please check if these records should be released:

___ Mental Health
___ Alcohol and/or Drug Abuse
___ Other (Specify): _____
___ Developmental Disabilities
___ Sexually Transmitted Diseases
___ Neuro-psychological Exams
___ HIV/AIDS Test Results

For the following date(s) or time frame: _____

5. Purpose of Disclosure: (Check applicable categories)

___ Further Medical Care
___ Insurance Eligibility/Benefits
___ Legal Investigation or Action
___ Personal
___ Changing Physicians
___ Other (Specify): _____
___ Treatment Plan Development

6. Expiration Date: This authorization will expire one (1) year from the date of my signature below or on this date _____ or at the time of this event (specify event) _____

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

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 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 My Choice Wisconsin Health Plan Inc.'s Health Information Clerk at 1-608-245-3109. I am aware that my withdrawal will not be effective as to 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.