my choice WISCONSIN Health Plan

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:

My Choice Wisconsin Health Plan Inc. Name of Health Care Provider/Plan/Other

1617 Sherman Avenue Street Address

Madison, WI 53704 City, State, Zip Code

4. Description of Health Information I Authorize to be Used and/or Disclosed (check all that may be disclosed).

- ☐ Medical History, Examination, Reports
- ☐ Treatment or Tests
- ☐ Immunizations
- ☐ X-ray Reports
- ☐ Laboratory Reports
- ☐ Entire Record
- ☐ 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 on _____, OR at the time of this event, (specify event or action _____). If blank, this authorization will expire one (1) year from the date of my signature below.

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.

- ✓ _____ **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.