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

Instructions to Provider: Copies of this authorization are as valid as the original: Please mail **or** fax the requested records by _____ to the address/fax number listed above.

I, _____ _____ M or F
(First MI Last) (Date of Birth) (Circle one)

authorize the following entities (e.g. Hospital, Doctor, Nursing Home, Home Health, Pharmacy, and Case Managers):

_____

_____

_____

_____

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_____

to use and disclose, in writing and verbally, information about me with MY CHOICE WISCONSIN HEALTH PLAN INC. for the purpose of developing a care plan, for My Choice Wisconsin Health Plan managed care programs. **I also grant permission to release information protected under Wisconsin Statute 51.30. Please release any notes or records requested pertaining to or treatment of Mental Health Information, Substance Abuse, Developmental Disabilities, Sexually Transmitted Diseases, and/or HIV test results.**

I authorize the use, disclosure and exchange of information between MY CHOICE WISCONSIN HEALTH PLAN INC. and County, State, and Federal oversight agencies or their authorized representatives. I understand that the information to be used or disclosed may no longer be protected once it is used or disclosed in accordance with this authorization. I understand that I may revoke this authorization at any time and that my revocation must be in writing. To obtain an authorization revocation form, I may contact the My Choice Wisconsin Health Plan Inc. Health Information Clerk at 608-245-3109. I understand that if I revoke this authorization, information already released may continue to be used to complete actions already initiated. Furthermore, I understand that if I revoke this authorization, My Choice Wisconsin Health Plan Inc. may not be able to adequately provide care for me. I understand that I have the right to inspect and copy the health information pertaining to this authorization in accordance with policies and procedures. I may contact My Choice Wisconsin Health Plan Inc.'s Health Information Clerk at 608-245-3109 for more information about those procedures.

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
___ Problem List
___ Laboratory Reports
___ Entire Record
___ Other (Specify):_____

___ Medication List
___ Hospital Records Including Reports
___ Recent Visits
___ Prescriptions
___ Consultations

___ Vocational Assessments
___ Behavior Plans
___ Residential Care Plans
___ School IEPs
___ Waiver ISPs
___ General Assessments

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.