

**MEMBER AUTHORIZATION**

This form is to be filled out by a member if there is a request to release the member's protected health information (PHI) to another person or company. When completed, it will allow Wisconsin Physicians Services Insurance Corporation (WPS or WPS Health Insurance), and/or its wholly owned subsidiaries, The EPIC Life Insurance Company (EPIC Specialty Benefits), and WPS Health Plan, Inc. (Arise Health Plan) (hereinafter "WPS Health Solutions"), to disclose the member's information to the person(s) or company(s) stated on this form. You must complete both pages of this form.

**PART A: MEMBER INFORMATION**

Member Last Name		Member First Name		M. I.	Member Date of Birth
Member Street Address			City	State	Zip Code
Daytime Phone #	Cell Phone #	Subscriber Number (ID Card)		Group Number (ID Card):	

**PART B: PERSON OR COMPANY WHO WILL RECEIVE INFORMATION**

The following people or companies have the right to receive my/the member's information. Please check each box that applies and enter first.

<input type="checkbox"/> Spouse/Domestic Partner (enter first and last name)	<input type="checkbox"/> Parents (if you are over 18 - enter first and last name(s))
<input type="checkbox"/> Company (enter company name and name of individual (if known))	<input type="checkbox"/> Insurance broker/agent (enter company, first and last name)
<input type="checkbox"/> Adult children (enter first and last name(s))	<input type="checkbox"/> Other (explain):

**PART C: INFORMATION THAT CAN BE RELEASED**

I allow the following information to be used or released by WPS Health Solutions on my behalf (check only ONE box):

**All of my information**, including health (e.g., claims, diagnosis, providers) and financial information (e.g., billing, banking information). This does not include sensitive information unless it is approved below. **OR**

**Only limited information** may be released (check all the boxes that apply to you):

Appeal  Eligibility & Enrollment  Referral  Benefits & Coverage  Financial  Treatment  Billing  Claims & Payment

Diagnosis (name of illness or condition) & Procedure (treatment)  Medical Records (excluding psychotherapy notes)  Doctor & Hospital

Prior Authorization (for treatment approvals)  Dental  Vision  Pharmacy  Member Services  Medical Management

Other: \_\_\_\_\_

I also approve the release of the following types of sensitive information by WPS Health Solutions (check all boxes that apply to you):

**All sensitive PHI (includes all information listed below)** **OR**  **Just sensitive PHI related to the topics checked below:**

Abortion  Genetic Testing  Mental Health  Abuse (sexual/physical/mental)  HIV or AIDS  Sexually Transmitted Illness

Alcohol/Substance Abuse\*\*  Maternity  Other: \_\_\_\_\_

\*\*I understand that my alcohol/substance abuse records are protected under Federal and State Confidentiality laws and regulations and cannot be disclosed without my written consent. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E below. I understand that I cannot cancel this approval when this form has already been used to disclose information.

**PART D: PURPOSE OF THIS APPROVAL**

To give out the information at my request **OR**

For this reason: \_\_\_\_\_

**PART E: DATE YOUR APPROVAL EXPIRES**

If this document was not already withdrawn, this approval will end on one of the earliest of the following dates:

One (1) year from the signature date in Part G **OR**

Upon the following specific date, event or condition, such as termination of the policy, completion of an appeal, etc. (please specify date, event, or condition):

\_\_\_\_\_

**\*\*MAIL COMPLETED FORM TO: WPS Privacy Office, P.O. Box 8190, Madison, WI 53708-8190  
OR FAX COMPLETED FORM TO: 608-977-9885**

**PART F: FORM OF INFORMATION REQUEST**

I authorize **WPS Health Solutions** to transmit the information identified in **Part C** above in the following format:

**Paper Copies.** Mail paper copies to the following address: \_\_\_\_\_

**Fax.** Fax the information to the following fax number: \_\_\_\_\_

**Digital Copies.** Mail CD/DVD to the following address: \_\_\_\_\_

**Email.** Email electronic copies to the following email address: \_\_\_\_\_

*NOTE: By requesting electronic copies and signing this form, I acknowledge that there are risks associated with transmitting my PHI, including sensitive PHI, (if selected above) via unsecure email, including that it may be intercepted, forwarded and printed and stored by others. I understand the risks involved in sending unsecure email and understand that WPS Health Solutions is not responsible for unauthorized access of PHI while in transmission to the third-party I have identified in Part B and is not responsible for safeguarding my information once it is delivered to the third party I direct.*

\*I understand that I may be charged a fee for copying and for any supplies (including CD/DVD) used to create the copy and postage fees for transmitting the information I have requested.

**PART G: REVIEW AND APPROVAL**

I have read the contents of this form. I understand, agree and allow WPS Health Solutions to use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that WPS Health Solutions does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits. I have the right to withdraw this approval at any time by giving written notice of my withdrawal to WPS Health Solutions. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that is released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

<b>Member Signature or Designated Legal Representative/Guardian Signature</b> X	<b>Date</b>
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**DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN**

If this form is signed by a personal representative, legal representative or guardian on behalf of the member, please submit the following with this completed form:

- A copy of a health care, general or Durable Power of Attorney (include proof of incapacity (if applicable)) **OR**
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal Representative (Print full Name)	Relationship to Member:	Phone Number:	
Legal Representative Street Address	City	State	Zip Code
<b>Signature</b> X			

**FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION**

**This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

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