

# HEALTH TRADITION HEALTH PLAN

P.O. Box 188 La Crosse, WI 54602-0188  
1-608-781-9692 1-888-459-3020 FAX 1-608-781-9654

## AUTHORIZATION FOR DISCLOSURE OF INFORMATION

<b>Member Name (Last Name, First Name)</b>	
<b>Address</b>	
<b>City</b>	
<b>State/Zip</b>	

<b>Birth Date</b>	<b>Maiden or Previous Name</b>	<b>Member ID Number</b>

1. I authorize Health Tradition Health Plan to release information from my health plan records as described in this form.
  
2. Health Tradition Health Plan may release information to the following individual or organization: *(Please print name, address, phone number and relationship – You may designate, for example: a person, a position within an organization or an organization. You may name your spouse, an adult child, parent, foster parent, stepparent, sibling, attorney, employer, domestic partner, guardian, other.)*

<b>Last name</b>	<b>First name</b>	<b>Phone #</b>	<b>Relationship</b>
<b>Street address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>

3. What type(s) of information may be released: *(Call your provider directly if you need to request medical records, including psychotherapy notes).*

**Administrative Information to be disclosed: (Check any or all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> Member number            | <input type="checkbox"/> Eligibility information, (for example: dates of coverage)  |
| <input type="checkbox"/> Benefit information      | <input type="checkbox"/> Disclose Address <span style="margin-left: 100px;"><input type="checkbox"/> Disclose Telephone Number</span> |
| <input type="checkbox"/> Premium information      | <input type="checkbox"/> Change address <span style="margin-left: 100px;"><input type="checkbox"/> Change telephone Number</span>     |
| <input type="checkbox"/> Claim/appeal information | <input type="checkbox"/> Specific claim/appeal information _____  |

*(If information includes HIV or mental health/chemical dependency records, Section 4 must be completed.)*

**Medical Information to be disclosed: (Check any or all that apply)**

- Referral or authorization determination/current status, or
- Medical history, diagnostic, and your care information, or
- Prescription Drug information, or
- The following information only: \_\_\_\_\_

(If information includes HIV or mental health/chemical dependency records, Section 4 must be completed.)

4. Member must initial for release of information for these special circumstances:

**Patient**

**Initials** \_\_\_\_\_ I also authorize the following persons access to my HIV antibody test results

**Patient**

**Initials** \_\_\_\_\_ I also authorize the following persons or agencies access to my mental health and/or chemical dependency records.

5. This disclosure is for (check appropriate box):

To aid in claim payment/referral determination.

Other, for the purpose of: \_\_\_\_\_

6. Permission expiration date: \_\_\_\_\_ *Note: If no date is given, it shall be valid for 24 months from the date shown below. This authorization is valid for a maximum of 30 months from date the authorization is signed.*

**I understand that:**

- ◆ I may revoke this permission at any time by submitting a request in writing to Health Tradition Health Plan.
- ◆ Revoking my permission does not apply to information that has already been released under this authorization.
- ◆ An electronic or photocopy version of this form is as valid as the original.
- ◆ If this information goes to a health care provider or a health plan covered by federal privacy laws, those laws protect it.
- ◆ Federal or state privacy laws may not protect information that goes to other persons or entities. It may be released again by the recipient without my permission.
- ◆ I do not have to sign this form. If I do not sign this form, Health Tradition Health Plan cannot release the information that I have asked to be released (above). Health Tradition Health Plan cannot condition treatment, payment, eligibility or enrollment on my signing this form.
- ◆ I am entitled to a copy of this form.

\_\_\_\_\_  
*Signature of member or member's legal representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print name*

\_\_\_\_\_  
*Relationship*

If signed by a member's legal representative, also submit a copy of legal authorization (for example: power of attorney, guardian, foster parent).

**Please complete and sign this form. Send to:**

**Health Tradition Health Plan  
P.O. Box 188 La Crosse, WI  
54602-0188  
Fax: 1-608-781-9653**