AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Please Return Completed Form to:

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

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

Date of Birth	Maiden or Previous Name	Member ID Number

- I authorize Health Tradition Health Plan to release information from my health plan records as described in this form.
- Health Tradition Health Plan may release information to the following person(s)/organization(s):

Last name	First name	Phone #	Relationship

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

- ☐ Membership/eligibility information *(for example: date of coverage or address changes)*
- ☐ Benefit information (*for example: your deductible, coinsurance, coverage, benefit quotes, etc.*)
- ☐ Billing/premium information
- ☐ All medical management information (*for example: prior authorization requirements, referral status*) **OR**
  - ☐ Specific authorization or referral status; please describe:
    ____
    ____
- ☐ All claim information *(for example: payments status)* **OR**
  - ☐ Specific claim information; please describe:
    ____
    ____
- ☐ All appeal status/outcome(s) **OR**
  - ☐ Specific appeal status/outcomes; please describe:
    ____
    ____
- ☐ Other; please describe:
  ____

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 upon request.

Please indicate the expiration date of this authorization. If you do not indicate a date, it will expire 24 months from the date the form is signed.

Expiration Date: ____/____/____

____ _________________________

Signature of Member or Member's Legal Representative* Date

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

Please Return Completed Form to:

Health Tradition Health Plan

P.O. Box 188 La Crosse, WI 54602-0188

Local 1-608-781-9692 Toll Free 1-888-459-3020 Fax 1-608-781-9654