network health

AUTHORIZATION FOR DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

☐ Medicare Member ☐ Other (Individual/Family or Insurance through Employer)

Member/Participant Information (individual whose information will be disclosed)

Your Name _____ Date of Birth ____/____/_____

Address _____ Member ID _____

Group Number (if applicable) _____ Phone Number _____

I authorize Network Health to disclose my personal health information to the following individual(s).

Name of Individual	*Name of Individual*
Street Address	*Street Address*
City, State, Zip	*City, State, Zip*
Phone Number	*Phone Number*
Relationship	*Relationship*

I authorize the following types of personal health information to be disclosed to the individuals listed above.

☐ Any and all protected health information Network Health maintains, including mental health, HIV, health status or substance abuse records. This also includes information on health programs, plan information and caregiver resources to the individuals being authorized.

☐ Protected health information about treatment for the following condition or injury, or other information (include dates).

_____

_____

Expiration Date

This authorization will remain in effect for the duration of the dates specified below or until you revoke this request, in writing. If only one, or no dates are specified below, this authorization is valid for 24 months from the date of your signature. **NOTE**: The use of words such as "present" or "indefinitely" are not valid and will be regarded as no dates.

From _____ to _____

Information about this document

This information is being disclosed to allow the individual(s) listed above to assist me with my Network Health plan.

I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal. I am aware that my withdrawal will not affect uses and/or disclosures of my health information made in reliance on this authorization before my written withdrawal was received.

I understand that I have the right to inspect or receive a copy of this authorization after I sign it.

I understand that I am under no obligation to sign this form and that Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC may not condition treatment, payment, **enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed to or received by persons/organizations who are not subject to Federal privacy standards, and may subject to redisclosure and no longer protected by Federal privacy standards.

***HIV Test Results: I understand my HIV test results may be released without authorization as set forth in Wisconsin law and a list of those persons/organizations is available upon request.*

****WI Statutes 51.30 and 252.15 requires patient authorization to disclose mental health treatment records and HIV test results for payment purposes.*

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE _____ **DATE** _____/_____/_____

☐ Member ☐ Legal Representative (must attach copies of authorization as required by law)

_____ _____

Relationship Authority