PERMISSION FOR DISCLOSURE AND USE OF MY PROTECTED HEALTH INFORMATION

Complete and mail this form to:
Network Health, Attn: Compliance Department, 1570 Midway Place, Menasha, WI 54952

Section A

Member information (person whose information will be released)

Name _____ Date of birth ____/____/____

Address _____

Phone number _____ Member ID _____

Section B

I give Network Health permission to disclose any and all protected health information Network Health possesses, including mental health, reproductive health, HIV, health status, genetic testing and/or substance abuse information to the people or organizations listed below. **You can designate up to two on this form.** This also includes information on health programs, plan information and caregiver resources, however they will not be able to change your plan, represent you in a claims appeal or decide what kind of care you get.

I understand that if those listed below are not a health care provider or health plan, the information disclosed to them may no longer be protected by federal privacy laws.

1. Person or organization Network Health can share my information with _____

Address _____

Relationship _____ Phone number _____

2. Person or organization Network Health can share my information with _____

Address _____

Relationship _____ Phone number _____

Section C

This form is not complete without your signature AND date. Please review the information and **sign and date** this form.

Information about this document

- I'm giving permission for Network Health to disclose my information to allow the people or organizations listed on the front side of this form to help me with my Network Health plan.
- I understand that I have the right to cancel this permission at any time by providing a written statement of cancelation to Network Health at the address listed below. I am aware that my cancelation will not affect the use and/or disclosures of my health information based on this permission before my written cancelation is received.
- I understand that I have the right to review or get a copy of this permission document after I sign it.
- I understand that signing this form is voluntary and that Network Health may not determine treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this document.

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

This permission is valid for two years from the date this form is signed or until I cancel the permission in writing, using the address below.

Signature _____ **Date** ____/____/____

☐ Check here if you are the member's legal representative (must attach copies of authorization as required by law)

_____ _____

Relationship Authority