network health

PERMISSION FOR DISCLOSURE AND USE OF MY PROTECTED HEALTH INFORMATION

There may be times when you may want a spouse, family member or caregiver to have access to your information to help you make decisions. In those cases, we need your permission to share your personal data with those people.

☐ I am a Medicare member
☐ I am a member of an Individual or Family Plan or have insurance through my employer

My Name _____ Date of Birth ____/____/____

Address _____ Member ID _____

Group Number (if applicable) _____ Phone Number _____

I give Network Health permission to disclose any and all protected health information Network Health possesses, including mental health, HIV*, health status and/or substance abuse information to the people listed below. This also includes information on health programs, plan information and caregiver resources.

Name of Person Network Health Can Share My Information With	*Name of Person Network Health Can Share My Information With*
Street Address	*Street Address*
City, State, Zip	*City, State, Zip*
Phone Number	*Phone Number*
Relationship	*Relationship*

Expiration of This Permission

This permission is valid for a **maximum of two years**. It will end either two years from the date this form is signed **or** the date stated below, whichever date comes first. This permission will stay in place for the duration of the time period stated below or until I cancel this permission in writing.

Permission is valid from _____ to _____.

Information about this document

I'm giving permission for Network Health to disclose my information to allow the people listed above 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. 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 understand that information used or disclosed based on the permission I'm approving may be disclosed to or received by people/organizations who are not subject to Federal privacy standards, and may be subject to submission to a third party and no longer protected by Federal privacy standards.

***HIV Test Results:** *I understand my HIV test results may be released without approval based on Wisconsin law, and a list of those people/organizations it may be released to is available upon request.*

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.

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

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

_____ _____

Relationship Authority