group health Cooperative of eau claire

Release of Information Form

Member Information		
Member Name (including any prior names)	Date of Birth	Member ID#
Address		Phone Number

Authorizes the Release of Information by:
Group Health Cooperative of Eau Claire
PO Box 3217
Eau Claire, WI 54702-3217
(715) 552-4300 or (888) 203-7770

Information to be Released to:
(Example: Parent, Son, Daughter, Lawyer, etc.)
Include name, address, phone and relationship

_____

_____

_____

Relationship _____

1. Purpose or need for the disclosure of your records (check all applicable categories):
   - ☐ **All Info**
   - ☐ Further Medical Care
   - ☐ Coordinating Care for Dependent/Spouse
   - ☐ Claims Resolution
   - ☐ Insurance Eligibility/Benefits
   - ☐ Other (please specify): _____

   _____

2. I authorize the following information to be used or disclosed:
   - ☐ **All Info**
   - ☐ Medical Files
   - ☐ Claims History
   - ☐ Other (please specify):_____

   _____

   All records from _____ to _____ (comments or instructions)

   _____

State and Federal laws require specific authorization prior to disclosing certain information. Please check if you would like any of the following specific information disclosed:

- ☐ **Mental Health Psychotherapy Notes**
- ☐ Alcohol and/or Drug Abuse
- ☐ Developmental Disability
- ☐ HIV Testing*

Please indicate specific dates (if any) associated ONLY for the above information:
From_____ to_____

Specific limitations requested ONLY for the above disclosures: _____

_____

*HIV TEST RESULTS: HIV test results may be released without authorization to certain persons/organizations, subject to applicable law. A list of persons/organizations entitled to receive this information is available upon request. By checking this box, I agree that my HIV test results may also be released to the person/organization identified above.

EXPIRATION DATE: This authorization is good until (indicate future date or event). _____
If this is left blank, this authorization is considered indefinite, subject to applicable law. By signing this authorization, I am confirming that it accurately reflects my wishes.

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Release of Information Form

If this form is not signed by the member, please identify the legal relationship to the member below. If you are Legal Guardian or Other, please provide a copy of the court order establishing the authority. If POA, please include a copy of the activation paperwork. For Legal Guardianship, please include a copy of the guardianship paperwork.

Please note that we cannot process this form without the proper documentation.

Signature of Member:	Date
or Signature of Parent/Guardian/Legal Representative:	Date

Member is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority: ☐ Parent of Minor ☐ Legal Guardian ☐ Health Care Agent
☐ Spouse or Personal Representative of Deceased ☐ Other

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

YOUR RIGHTS REGARDING THIS AUTHORIZATION:

- **Right to Receive Copy of This Authorization** - I understand that if I sign this authorization, I have the right to receive a copy upon request.
- **Right to Inspect Health Information Disclosed** - I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form. I may arrange to review any disclosures of my health information under this authorization by contacting the Group Health Compliance Department.
- **Right to Refuse to Sign This Authorization** - I understand that I am not required to sign this form; however, if I refuse to sign this authorization, I understand that Group Health Cooperative of Eau Claire may not be able to disclose the health information as requested in this authorization. Group Health Cooperative of Eau Claire may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization, except regarding: (a) research-related treatment or (b) health plan enrollment or eligibility. I understand that not all disclosures of my medical information require my authorization. Further information regarding disclosures that may occur without authorization may be found on Group Health Cooperative of Eau Claire's Notice of Privacy Practices.
- **Right to Withdraw This Authorization** - I understand that I have the right to withdraw this authorization at any time by contacting Group Health Compliance Department and requesting a withdrawal in writing. I understand that my withdrawal will not be effective until received and processed by Group Health Compliance Department and will not be effective as to any uses and/or disclosures that occurred prior to receipt of my request to withdraw this authorization. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other laws may provide Group Health Cooperative of Eau Claire with the right to contest a claim.

QUESTIONS or CONCERNS?

For questions regarding the completion of this form, or the documents required to accurately complete this form, please contact **Member Services at (715) 552-4300 or (888) 203-7770**.

For questions regarding your right to access your health information, who Group Health Cooperative of Eau Claire may release information to without your authorization, or to report a potentially unauthorized disclosure, please contact our **Compliance Department at (715) 552-4300**.

Group Health Cooperative of Eau Claire complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, age, disability, sex, religion, political beliefs, sexual orientation, or filing of a prior civil rights complaint.

Group Health Cooperative of Eau Claire provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, including qualified interpreters and information written in other languages. If you need these services, contact Member Services at: (888) 203-7770 (TTY: 711).

English – ATTENTION: If you speak English, language assistance services are available to you free of charge. Call 1-888-203-7770 (TTY: 711).

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-203-7770 (TTY: 711).

Hmong – LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-203-7770 (TTY: 711).

Chinese – 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-203-7770 (TTY: 711).

Laotian – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-203-7770 (TTY: 711).

Somali – DIGTOONI: Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa laguu heli karaa iyagoo bilaash ah. Wac 1-888-203-7770 (TTY: 711).

Serbo-Croatian – OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-203-7770 (TTY - Telefon za osobe sa oštećenim govorom ili sluhom: 711).
