WPS HEALTH SOLUTIONS | WPS HEALTH INSURANCE | Arise HEALTH PLAN | EPIC SPECIALTY BENEFITS

MEMBER AUTHORIZATION

This form is to be filled out by a member if there is a request to release the member's protected health information (PHI) to another person or company. When completed, it will allow Wisconsin Physicians Services Insurance Corporation (WPS or WPS Health Insurance), and/or its wholly owned subsidiaries, The EPIC Life Insurance Company (EPIC Specialty Benefits), and WPS Health Plan, Inc. (Arise Health Plan) (hereinafter "WPS Health Solutions"), to disclose the member's information to the person(s) or company(s) stated on this form. You must complete both pages of this form.

PART A: MEMBER INFORMATION

Member Last Name	Member First Name	M. I.	Member Date of Birth

Member Street Address	City	State	Zip Code

Daytime Phone #	Cell Phone #	Subscriber Number (ID Card)	Group Number (ID Card):

PART B: PERSON OR COMPANY WHO WILL RECEIVE INFORMATION

The following people or companies have the right to receive my/the member's information. Please check each box that applies and enter first.

☐ Spouse/Domestic Partner (enter first and last name)	☐ Parents (if you are over 18 - enter first and last name(s))
☐ Company (enter company name and name of individual (if known))	☐ Insurance broker/agent (enter company, first and last name)
☐ Adult children (enter first and last name(s))	☐ Other (explain):

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by WPS Health Solutions on my behalf (check only ONE box):

☐ **All of my information**, including health (e.g., claims, diagnosis, providers) and financial information (e.g., billing, banking information). This does not include sensitive information unless it is approved below. **OR**

☐ **Only limited information** may be released (check all the boxes that apply to you):

☐ Appeal ☐ Eligibility & Enrollment ☐ Referral ☐ Benefits & Coverage ☐ Financial ☐ Treatment ☐ Billing ☐ Claims & Payment

☐ Diagnosis (name of illness or condition) & Procedure (treatment) ☐ Medical Records (excluding psychotherapy notes) ☐ Doctor & Hospital

☐ Prior Authorization (for treatment approvals) ☐ Dental ☐ Vision ☐ Pharmacy ☐ Member Services ☐ Medical Management

☐ Other:____________________

I also approve the release of the following types of sensitive information by WPS Health Solutions (check all boxes that apply to you):

☐ **All sensitive PHI (includes all information listed below)** **OR** ☐ **Just sensitive PHI related to the topics checked below:**

☐ Abortion ☐ Genetic Testing ☐ Mental Health ☐ Abuse (sexual/physical/mental) ☐ HIV or AIDS ☐ Sexually Transmitted Illness

☐ Alcohol/Substance Abuse** ☐ Maternity ☐ Other:____________________

I understand that my alcohol/substance abuse records are protected under Federal and State Confidentiality laws and regulations and cannot be disclosed without my written consent. I also understand that I may revoke (or cancel) this approval at any time, or as described in **Part E below. I understand that I cannot cancel this approval when this form has already been used to disclose information.

PART D: PURPOSE OF THIS APPROVAL

☐ To give out the information at my request **OR**

☐ For this reason:____________________

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end on one of the earliest of the following dates:

☐ One (1) year from the signature date in **Part G** **OR**

☐ Upon the following specific date, event or condition, such as termination of the policy, completion of an appeal, etc. *(please specify date, event, or condition):*

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****MAIL COMPLETED FORM TO: WPS Privacy Office, P.O. Box 8190, Madison, WI 53708-8190**

OR FAX COMPLETED FORM TO: 608-977-9885

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PART F: FORM OF INFORMATION REQUEST

I authorize WPS Health Solutions to transmit the information identified in **Part C** above in the following format:

☐ **Paper Copies.** Mail paper copies to the following address:____________________________

☐ **Fax.** Fax the information to the following fax number:____________________________

☐ **Digital Copies.** Mail CD/DVD to the following address:____________________________

☐ **Email.** Email electronic copies to the following email address:____________________________

NOTE: By requesting electronic copies and signing this form, I acknowledge that there are risks associated with transmitting my PHI, including sensitive PHI, (if selected above) via unsecure email, including that it may be intercepted, forwarded and printed and stored by others. I understand the risks involved in sending unsecure email and understand that WPS Health Solutions is not responsible for unauthorized access of PHI while in transmission to the third-party I have identified in Part B and is not responsible for safeguarding my information once it is delivered to the third party I direct.

*I understand that I may be charged a fee for copying and for any supplies (including CD/DVD) used to create the copy and postage fees for transmitting the information I have requested.

PART G: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree and allow WPS Health Solutions to use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that WPS Health Solutions does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits. I have the right to withdraw this approval at any time by giving written notice of my withdrawal to WPS Health Solutions. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that is released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member Signature or Designated Legal Representative/Guardian Signature **X**	**Date**

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN

If this form is signed by a personal representative, legal representative or guardian on behalf of the member, please submit the following with this completed form:

- A copy of a health care, general or Durable Power of Attorney (include proof of incapacity (if applicable)) **OR**
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal Representative (Print full Name)	Relationship to Member:	Phone Number:	
Legal Representative Street Address	City	State	Zip Code
Signature **X**			

FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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