Physicians Plus
More Physicians. More Clinics. Better Choices.

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Disclosure Authorization Form See directions on p. 2.

SECTION A: Must be completed for all authorizations

I hereby authorize Physicians Plus Insurance Corporation to use or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary.

Member Name: Member ID#:

Person/organization PROVIDING the information: Person/organization RECEIVING the information:

Specific description of information authorized to be used or disclosed, including dates.

Specify any restrictions regarding Physicians Plus departments or personnel:

In compliance with Wisconsin Statutes, which requires special permission to release otherwise privileged information, please release records pertaining to:

☐ Alcohol/Drug Abuse ☐ Mental Health ☐ HIV related information
☐ Sexually transmitted Disease ☐ Genetic Testing ☐ Developmental disabilities

SECTION B: Describe the purpose or need for an authorization

☐ Claims resolution ☐ Complaint/Grievance ☐ Coordinating care for dependent or spouse
☐ Pharmacy–Specify: ☐ Coordination of benefits ☐ Other–Specify:

SECTION C: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

I understand that I, or my personal representative, is entitled to receive a copy of the completed authorization form*. **Please retain a signed copy of the authorization for your records.**

I understand that this authorization will remain valid for **one year** from the date of my signature unless stated otherwise. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and submit my written revocation to Member Service as described in the Notice of Privacy Practices. I understand that the revocation will not apply to information already released. I also understand that once the information is released to others, it may be re-disclosed to individuals or organizations not subject to state and federal privacy and confidentiality laws and may not be protected. Physicians Plus will not condition payment, enrollment or eligibility for benefits in the health plan on the signing of the authorization, unless otherwise permitted by state and federal privacy laws.

Signature of member/patient or legal representative Date

If signed by legal representative, describe your relationship to the member

Disclosure Authorization Form Directions

This form is for use when:

- A member asks a third party or person who is not a contracted agent of Physicians Plus to act on their behalf.
- Family members call on behalf of their spouse, divorced spouse or adult dependent (18 and up) and they are seeking more than general claims and billing information.
- An employee feels that, in their professional judgment or at the discretion of their manager, it is warranted.
- Someone other than the individual is seeking information pertaining to dependents 14 or older that involves alcohol, mental health, obstetrical or gynecological care.

Directions:

Section A.

1. The member's full name (for which disclosure is requested) must be completed, including the member number or social security number, for verification purposes.
2. Person/organization providing the information: write in the name of the person or organization supplying information. This is usually Physicians Plus. For example, if a member asks their employer to resolve a claims issue and the employer requests information from Physicians Plus, the person supplying the information would write in Physicians Plus and their name.
3. Person/organization receiving the information: as in the example above, if the employer is seeking information on behalf of the member, write in the employer's name and the name of the person at the employer's office.
4. Specific description of information authorized for disclosure. Supply sufficient detail about the type of information requested and provided. Include the range of dates of service. The range can be a span of dates or a single date of service. A Physicians Plus employee or the person completing the form may fill out the date of service.
5. The individual has a right to restrict any information or personnel from using or disclosing their protected health information.

Section B

6. Describe the purpose or need for the authorization. The member or Physicians Plus employee may check or describe the purpose or need for the authorization. For example, if an employer wanted to settle a claims dispute on behalf of an employee, simply check the "claims resolution" box.

Section C

7. This information notifies the member of their rights. State and federal law requires this section and its contents. It is not subject to change by any employee. However, a member could cross out the "valid for one year" and enter a suitable timeframe with which they are comfortable. The clause stating that information may be re-disclosed means that if Physicians Plus, at the request of the member, provides information to an employer, that employer is not required by law to protect that information because employers are not covered entities.
8. Signature and date are required. If the member, adult dependent (over 18) or legal representative does not sign and date the authorization, it is not valid.
    - If a legal representative signs the authorization, we are required by law to document the relationship to member.
    - Each member has a right to receive a completed signed copy of the authorization form. If the member fails to retain a copy for their records and requests a copy, make a copy of the authorization and send as instructed.
9. All authorization forms must be documented in the claims system and filed in the designated record set.

Please print, complete, sign and fax the authorization to Health Services at (608) 327-0322, Member Service at (608) 327-0321, or Pharmacy Services at (608) 327-0324, or mail to the address at the top of page one.