WISCONSIN MEDICAID

HIPAA PRIVACY AUTHORIZATION FOR USE OR DISCLOSURE

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require DHS, as a covered entity, to implement processes that give members certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Provision of the information that is requested on this form is voluntary. Although the use of this version of the form is voluntary, all of the information outlined on this form is mandatory.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

INSTRUCTIONS: Mail this completed form to the following address:

Wisconsin Medicaid
Member Services
PO Box 6678
Madison WI 53716-0678

You are entitled to a copy of this authorization after you sign it.

SECTION I — Member INFORMATION

Name — Last, First, Middle Initial	Wisconsin Medicaid Identification Number
Address — Street, City, State, ZIP Code	Telephone Number ( )

SECTION II — THE USE AND / OR DISCLOSURE BEING AUTHORIZED

Purpose of the use or disclosure: Describe the purpose of the requested use or disclosure.

Health Information to be used or disclosed: Please specifically describe the health information records and the dates of the records you are authorizing be used and/or disclosed.

Person or Organization I Authorize to Disclose Health Information: Name or specifically identify the persons or organizations, including the Wisconsin Division of Health Care Access and Accountability (DHCAA), who you are authorizing to disclose the health information described above. *Please include the address and telephone number for persons and/or organizations other than the DHCAA.*

Name	Telephone Number ( )
Address	

Name	Telephone Number ( )
Address	

Continued

SECTION II — THE USE AND / OR DISCLOSURE BEING AUTHORIZED (Continued)

Person or Organization to Receive and Use: Name or specifically describe the persons or organizations, including addresses and telephone numbers, to whom you are authorizing the DHCAA to disclose to or let use the health information as previously described:

Name	Telephone Number
	( )
Address	

Name	Telephone Number
	( )
Address	

I understand that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. State health record privacy regulations will still apply to my health information.

SECTION III — EXPIRATION AND REVOCATION

Expiration: This authorization will expire as follows (complete one):

❑ On ____ / ____/ _____ (MM/DD/YYYY), or

❑ On occurrence of the following event (which must relate to the member or to the purpose of the use or disclosure being authorized):

Right to Revoke: I understand that I may revoke all or part of this authorization at any time by giving written notice of my revocation to the Privacy Office information listed below. I understand that revocation of this authorization will *not* affect any action taken in reliance on this authorization before receiving my written notice of revocation.

Wisconsin Medicaid
Member Services
PO Box 6678
Madison WI 53716-0678

SECTION IV — SIGNATURES

I, _____**,** have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the DHCAA. I understand that, by signing this form, I am confirming my authorization that the DHCAA may use or disclose to the persons or organizations named in this form the health information described in this form. I also understand that the DHCAA will not condition payment, enrollment, or eligibility for benefits in the DHCAA on the signing of this authorization.

SIGNATURE — Member	Date Signed

If this authorization is signed by a personal representative on behalf of the member, provide a copy of the documentation to support the representation and complete the following:

Name — Personal Representative	Relationship to Member

SIGNATURE — Personal Representative	Date Signed

RESET FORM