HEALTH TRADITION P.O. Box 21171 | Eagan, Minnesota 55121 | 877.832.1823 | healthtradition.com

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION BY PROVIDER

Health Tradition is requesting health information about you. Your health care provider must have your permission to share your health information with us.

Complete this authorization form to give your provider permission to disclose (or share) your health information with Health Tradition.

INSTRUCTIONS FOR COMPLETION

1. Print or type.
2. Use blue or black ink.
3. **Participant/Subscriber's Name:** Your name or your dependent's name.
4. **Address, Phone Number:** Your (or your dependent's) address and phone number.
5. **Birth date:** Your (or your dependent's) birth date.
6. **Authorizes:** Write the name and address of the health care provider or organization (clinic, hospital, nursing home) that has your health information to be shared. Use a new form for each person or organization.
7. **Information to Share:** What information do you want to share? If you talked with an employee from Health Tradition, check all the boxes the employee told you to check.
8. **For the Following Dates**: What is the time frame for the information you want to share? For example, "heart surgery in October 2016" or "counseling during 2016–2017," or "all information after 01/01/2016."
9. **Reason:** Why are you sharing your information? If you talked with an employee from Health Tradition, check all the boxes the employee told you to check.
10. **Expiration Date:** For how long is your authorization, or permission, active? Write a specific date or an event. If you don't write anything, your authorization is active for 1 year.
11. **Participant/Subscriber's Signature:** Your signature (and your dependent's signature, if age 14 or older).
    - **For dependents 14 to 18 years old, the parent/legal representative must also sign the form.**
    - For an adult who cannot sign, the parent/legal representative must sign the form and write why they are signing (disability or health condition).
12. **Date:** What is the date you are signing the form?
13. Send the complete form **to the person or organization you identified in #6**.

HEALTH TRADITION P.O. Box 21171 | Eagan, Minnesota 55121 | 877.832.1823 | healthtradition.com

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION BY PROVIDER

Please print or type and use blue or black ink.

Name of Participant/Subscriber _____ Participant/Subscriber Birth Date _____

Address (Street, City, State, Zip Code) _____ Subscriber Number/Group Number _____

Authorizes:

HEALTHCARE PROVIDER/FACILITY _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____

To Share My Health Information with:

Health Tradition
P.O. Box 21171
Eagan, MN 55121

Information to Share: (Choose all of the information you want to share)

- ☐ Admission and Discharge Summary
- ☐ Progress Notes
- ☐ Medical History & Medications
- ☐ Surgical Reports
- ☐ X-ray Reports
- ☐ Laboratory Reports
- ☐ Psychiatric, Social, Psychological, and Other Allied Health Evaluations
- ☐ Other (Specify): _____

For the Following Dates: _____

Reason:

- ☐ Payment of claim(s)
- ☐ Coordination of Benefits
- ☐ Preauthorization
- ☐ Case Management
- ☐ Other (Specify): _____

I understand:

- I can end this permission at any time by writing a request to the person/organization who is sharing my information. The permission will not end until the person/organization receives my written request.
- There is no change to information shared before the person/organization receives my written request to stop permission.
- I do not have to sign this form. If I do not to sign this form, my insurance will not be able to review required information and might not be able to pay for treatment I receive from the person/organization listed above.
- I can ask for a copy of this form.
- I can ask to review and/or receive a copy of the health information I am sharing. To do this, I might have to pay a reasonable fee. I must send a written request to Health Tradition's Office of General Counsel to ask for a copy.
- This authorizes Health Tradition to disclose and discuss past, present, and future health information pursuant to the request, unless I revoke this authorization. **(Redisclosure Notice)**
- My permission is active for 1 year from the date I sign, unless I write a different date or event below.
  Expiration Date: _____

I give my permission to this person/organization to share my health information with Health Tradition (my insurer). I understand that some information might have extra protection under Wisconsin or federal law, including information about mental health, alcohol and/or drug abuse, and developmental disabilities. If this information is in my health record, I give my permission to share it with Health Tradition. I have reviewed this form and understand it. By signing, I confirm that it explains my wishes correctly.

Individual's Signature if age 14 or older _____ Date _____

Signature of Parent/Legal Guardian if individual is under 18, or not able to sign. _____ Date _____

If individual is 18 or older and cannot sign, write the reason (ex. disability) and signer's relationship to individual: _____

A photocopy of this form is as valid as the original.