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

AUTHORIZATION TO SHARE HEALTH INFORMATION WITH A THIRD PARTY

Use this form to:

- Share your health information with someone who is **not** immediate family (a union representative, lawyer, friend, etc.).
- Share **only specific** health information with **immediate family** (spouse, parent, step-parent, child, sibling, or domestic partner). For example: share specific information about an operation with your child (not all your health information).

Use the **Designation of an Insurance Representative** form if you are an adult and you want an immediate family member (spouse, parent, step-parent, child, sibling, or domestic partner) to have access to **all** of your health information.

INSTRUCTIONS FOR COMPLETION

1. Print or type.
2. Use blue or black ink.
3. **Participant/Subscriber's Name and Birth Date:** Whose information do you want to share? Please print your name and birth date if it is your information being shared, or your dependent's name and birth date if it is for their information.
4. **Address, Phone Number:** Your (or your dependent's) address and phone number.
5. **Share My Protected Health Information with:** Who will have access to your health information? Please print the name, address, and phone number.
6. **Information to Share:** What information do you want to share? You can check more than 1 box. If you want to share **all** of your information, check the "other" box, and write: "all information about coverage and benefits" in the blank.
7. **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."
8. **Reason:** Why are you sharing your information? Check all the reasons that apply.
9. **Participant/Subscriber's Signature:** Your (or your dependent's) signature.
10. If the individual is under 18 years old, the parent/legal representative must sign the form and write their relationship to the individual.
11. 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 completed form to the department that asked you to complete the form.
14. Beside the name of the department, write "Authorization" on the envelope.
15. Send it to Customer Service if you don't know the name of the department.

Address envelope: Health Tradition
Attn.: **Customer Service—*Authorization***
P.O. Box 21171
Eagan, MN 55121

Or Fax: (608) 781-9654

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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 _____

Share My Protected Health Information with:

NAME OF INDIVIDUAL/ORGANIZATION _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

PHONE NUMBER _____

Information to Share:
I give permission for Health Tradition to share the following information* with the person/organization I wrote above:

☐ Case management records ☐ Payment Summary ☐ Enrollment records ☐ Claim history/correspondence
☐ Provider records/correspondence ☐ Other (Specify): _____

*I give Health Tradition permission to share all of my information with the person/organization I wrote on this form, including protected information like: mental health, alcohol and drug abuse, and developmental disabilities.

For the Following Dates: _____

I understand that portions of my records may have extra protection under Wisconsin statutes or federal law, including information relating to mental health, alcohol and/or drug abuse, and developmental disabilities. However, if any such information is included in the information held by my insurer, I understand that my insurer will not attempt to separate out such information; thus, specially protected information may be disclosed pursuant to this request. I hereby authorize the disclosure of that information.

Reason: ☐ Payment of claim(s) ☐ Coordination of Benefits ☐ Preauthorization ☐ Grievance/appeal
☐ Other (Specify): _____

Dates Covered: This form gives Health Tradition permission to talk about past, present, and future information with the person/organization listed above, for as long as I am covered under a Health Tradition plan for the specified timeframe given.

To stop this permission, I can send a written request to Health Tradition. I understand that Health Tradition will stop sharing my information when they receive my written request. My request does not affect information Health Tradition shared before they received it.

Redisclosure Policy: I understand that after Health Tradition shares my information with the person/organization above, the information is not protected by federal and state privacy standards. Health Tradition is not responsible if the person/organization shares my information with someone else.

I understand I do not have to sign this form. When I sign this form, I confirm that it correctly describes what I want.

Participant/Subscriber's Signature _____ Date _____

If the individual is 18 or older but cannot sign, the spouse/parent/legal representative must sign the form and write why they are signing (disability or health condition).

_____

Send the completed form to:

Health Tradition, P.O. Box 21171, Eagan, MN 55121 or Fax: (608) 781-9654