Authorization to Disclose Health Information

Notice to Member:

- Completing this form will allow MHS Health Wisconsin to share your health information with the person or group that you identify below.
- You do not have to sign this form or give permission to share your health information. Your services and benefits with MHS Health Wisconsin will not change if you do not sign this form.
- Right to cancel (revoke): If you want to cancel this Authorization Form, fill out the Revocation Form on the next page and mail it to us at the address at the bottom of the page.
- MHS Health Wisconsin cannot promise that the person or group you allow MHS Health Wisconsin to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. MHS Health Wisconsin can send you copies if you need them.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the page.

Member Information:

Member Name (print): ____

Member Date of Birth: ___/_____/_____ Member Medicaid ID Number: ______________________________

I give MHS Health Wisconsin permission to share my health information with the person or group named below. The purpose of the authorization is to help me with my MHS Health Wisconsin benefits and services.

Who is Allowed to receive Member Information:

Name (person or group): ____

Address: ____

City: __________________________ State: ___________________ Zip: ___________ Phone: (____) ____ - ______

MHS Health Wisconsin can share this Health Information: (check all boxes that apply)

☐ All of my health information; **OR**

☐ All of my health information **EXCEPT**:

- ☐ Prescription drug/medication information
- ☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) information
- ☐ Treatment for alcohol and/or substance abuse information
- ☐ Behavioral health services or psychiatric care information
- ☐ Other: ____

Authorization End Date: ______/_____/_____ (enter date authorization ends; unless later cancelled in writing using the revocation form; date must be filled in or write "none" for no end date)

Member Signature: ____ **Date**: ____/____/______

(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

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Mail To: MHS Health Wisconsin, 10700 W Research Dr., Ste. 300, Milwaukee, WI 53226
Phone: (800) 547-1647 or TDD/TTY (800) 947-3529

Revocation of Authorization to Disclose Health Information

I want to cancel, or revoke, the permission I gave to MHS Health Wisconsin to share my health information with this person or group:

Recipient Information:

Name (person or group): ____

Address: ____

City: __________________________ State: ___________________ Zip: ___________ Phone: (____) ____ - ______

Authorization Signed Date (if known): _______/_______/_______

Member Information:

Member Name (print): ____

Member Date of Birth: ______/______/_______ Member Medicaid ID Number: _______________________________

I understand that my health information may have already been shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to share my health information with this person or group. It does not cancel any other authorization forms I signed for health information to be shared with another person or group.

Member Signature: ____ **Date**: ____/____/______

(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

____

MHS Health Wisconsin will stop sharing your health information when we get this form. Use the mailing address below. You can also call for help at the number below.

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Phone: (800) 547-1647 or TDD/TTY (800) 947-3529