Authorization to Release Health Information

Directions: Complete each of the following sections below. This authorization is not valid or effective until you or your legally authorized representative complete each section, then sign, date and return the form. Your legally authorized representative must provide proof of his or her authority to act on your behalf. **Note:** This authorization does not affect or change the routine sharing of my health information by or between affiliates and/or any providers that is permitted or required under Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other applicable federal or state law.

Return completed form to: Aspirus Health Plan, ATTN: Customer Service, PO Box 1062, Minneapolis, MN 55440
or email to: CustomerService@aspirushealthplan.com. If you have questions, please call Customer Service at: 866.631.5404.

Full Name (First, Middle and Last)		Previous Last Name, if any	
Street Address	City	State	Zip Code
Birth Date	Phone Number	Member ID Number	Employer Name and Group Number

1. **Identify the Health Information that you authorize to be communicated, received, disclosed and used with others** *(Select one):* Your "Health Information," includes, but is not limited to your "protected health information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA") and patient health care records as defined by Wisconsin Statute Section 146.81. Your Health Information includes your past, present and future Health Information, and includes but is not limited to, medical and pharmacy claims records, and related case notes and information derived from them; and which specifically include, if Aspirus Health Plan has them, claims and case notes and information derived from them about HIV/AIDS, and mental health and substance use *(except see section 3 about psychotherapy notes and certain substance use information)*.
   a. ☐ All of my Health Information (defined above) for all dates and periods of time.
   b. ☐ All of my Health Information (defined above) for the following specific date(s) or period(s) of time:

      _____

   c. ☐ Include for (check one) ☐ all dates and periods of time; or ☐ the following specific date(s) or period(s) of time:

      _____ only the following Health Information (describe below):

2. **Psychotherapy notes, or substance use disorder information derived from a treatment program or health care provider that receives federal funding.** Federal law requires specific consent for the release of this information. You must complete this section to authorize the communication of, receipt, disclosure and/or use of any psychotherapy notes, or to authorize the communication, receipt, disclosure and/or use of certain substance use disorder information derived from a treatment program or health care provider that receives federal funding. Any information communicated, received, disclosed and/or used pursuant to this section 2 is your Health Information.

Psychotherapy Notes

   a. ☐ Include all psychotherapy notes.
   b. ☐ Include only psychotherapy notes for the following date(s)/time period:

   c. ☐ Include for (check one) ☐ all dates and periods of time; or ☐ the following specific date(s) or period(s) of time:

      _____ only the following psychotherapy notes (describe below):

Substance Use Disorder Information

   a. ☐ Include all substance use disorder information.
   b. ☐ Include only substance use disorder information notes for the following date(s)/time period:

   c. ☐ Include for (check one) ☐ all dates and periods of time; or ☐ the following specific date(s) or period(s) of time:

      _____ only the following substance use disorder information (describe below):

3. **Identify the person(s) and/or entity(ies) to whom or to which you authorize the communication, receipt, disclosure and/or use your Health Information** *(Provide complete name, relationship (if a family member), company name if applicable, address and phone number. Add an attachment if more space is needed.):*

   a. Family member or legally authorized representative:

   b. Provider and/or clinic:

   c. Lawyer and/or law firm:

   d. Other person or entity:

4. **Identify the reason for the release or disclosure of your Health Information:**

   a. ☐ Member's request
   b. ☐ Payment
   c. ☐ Appeal of a denied claim
   d. ☐ Legal/litigation
   e. ☐ Other (explain):

5. **Identify the date this authorization expires** *(Select one)***:**

   a. ☐ This authorization is effective until my health coverage under the above Member Number ends.
   b. ☐ This authorization is effective for one year from the date I sign it.
   c. ☐ This authorization is effective for less than one year from the date I sign it, and until _____

6. **Acknowledgements and Signature**

By executing this Authorization, I understand and agree that:

- This authorization allows the communication, receipt, disclosure, and/or use of my Health Information (defined above).
- I have not been required to sign this form and am doing so voluntarily. I am not required to sign this form to receive health benefits.
- I may inspect or copy the Health Information that is released or disclosed.
- I may prospectively revoke this authorization at any time by contacting Customer Service at 866.631.5404. If I do revoke this authorization, it will only stop the release of Health Information in the future and does not apply to Health Information already released.
- Once it is released, the Health Information that is used or disclosed pursuant to this authorization is no longer protected by us or federal and state privacy laws. The recipient might re-disclose it.

Member Signature	Print Member Name	Date
Legally Authorized Representative* Signature	Print Name and Relationship to Member	Date

*If you are the member's legally authorized representative as defined by HIPAA or other applicable federal and state law, you must submit the applicable documentation or other proof of legally authorized representative status that establishes your authority including but not limited to:
*__Power of Attorney__ – *Valid power of attorney document* __*Guardian__ – *Valid court order appointing you as guardian* __*Executor__ – *Valid court order appointing you as executor of a decedent's estate. Legally authorized representatives must provide notice of any change to their status or authority.*

Date Received by _____ Initials _____

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. *We* do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:
Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If *you* need these services, contact *us* at the phone number shown on the inside cover of this *contract*, *your* id card, or aspirushealthplan.com.

If *you* believe that *we* have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, *you* can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1.866.631.5404 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً . اتصل بن اعلى رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_: य_द आप ि हंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 致電 1.866.631.5404 (TTY:711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.866.631.5404 (TTY:711).