Request for Copies of My Medical Information

45 CFR §164.524, Wis. Stat. §40.07(2)

Wisconsin Department
of Employee Trust Funds
PO Box 7931

Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

The Wisconsin Department of Employee Trust Funds requires this form to be completed when a member requests copies of their medical information. This ensures we are fulfilling your request accurately and in a timely manner, and in accordance with HIPAA requirements.

Member Whose Medical Information Can Be Disclosed

Name (first, middle, last, former/maiden)		
Birth date (MM/DD/YYYY)	Telephone, including area code	ETF Member ID or Last 4 of SSN
Address (street)		
City State ZIP code		Email

Description of the Medical Information to Be Disclosed

☐ All medical information contained in my ETF records

☐ Medical information pertaining to:

☐ Date Range From (MM/DD/YYYY):_____To (MM/DD/YYYY):_____

☐ Information related to a specific service or benefit (Describe) _____

☐ Other (Describe) _____

Sign on the next page. This form cannot be accepted without a signature.

Signatures

Please read carefully. **Complete only one of the sections below:**

Section 1 if you are the member requesting release of your information.
or
Section 2 if you are an individual acting on behalf of the member to whom the information belongs.

Section 1. Member Signature

I understand that by signing this form, I am giving ETF, and entities that perform contracted services for ETF, permission to use and/or disclose my medical information as described in this form. In addition, I understand the following:

- I may revoke this document at any time by notifying ETF in writing, but my revocation will not affect any actions ETF, or other entities that provide contracted services for ETF, took before receiving the revocation.
- Payment, enrollment, or eligibility for benefits will not be affected if I do not sign this form.
- A photocopy of this document shall have the same effect as the original. However, ETF reserves the right to request the original or additional identifying information before complying with any such request.

Signature	Date

OR

Section 2. Legal Representative Signature

My signature on this form confirms that I have the proper authority to submit it to ETF. I understand that by signing this form I am giving ETF, and entities that perform contracted services for ETF, permission to use and/or disclose the named individual's medical information. In addition, I understand the following:

- I may revoke this document at any time by notifying ETF in writing, but my revocation will not affect any actions ETF, or other entities that provide contracted services for ETF, took before receiving the revocation.
- Payment, enrollment, or eligibility for benefits for the named individual will not be affected if I do not sign this form.
- A photocopy of this document shall have the same effect as the original. However, ETF reserves the right to request the original or additional identifying information before complying with any such form.

Information About the Legal Representative

I am the (Check one): ☐ Conservator ☐ Guardian ☐ Power of Attorney

Applicable documentation must be submitted and approved by ETF.

Name (first, middle, last)	Relationship to member

Address (street)	City	State	ZIP code

Birth date (MM/DD/YYYY)	Telephone, including area code	Email

Signature	Date

If you have questions or concerns about obtaining copies or inspecting your ETF medical information, contact the ETF Privacy Officer at etfsmbprivacyofficer@etf.wi.gov or 1-877-533-5020.