Authorization to Disclose Medical Information

45 CFR § 164.508; Wis. Stat. § 40.07 (2);
Wis. Adm. Code § ETF 10.01 (3m)

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

Completion of this form gives the Wisconsin Department of Employee Trust Funds, and entities that perform contracted services for ETF, permission to release your designated medical information, including medical records and protected health information, to a person or entity specified by you.

Member Whose 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		Email

Description of 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): _____

Scope of Request

Check the box that applies to this request:

- ☐ Send requested information above at this time *and* retain this authorization for future use.
- ☐ No information is needed at this time. Place this authorization in my file for future use.

Individual or Entity to Receive Information

Type or print the name and address of the person or entity to whom information may be released (if more than one, use a separate form for each).

Name (first, middle, last, former/maiden)	Relationship to member
Business entity name (if applicable)	Telephone, including area code
Address (street) City State ZIP code	Email

Effective Dates

This authorization will expire six (6) months from the date of signature unless it is revoked sooner in writing, or another expiration date is specified below. Regardless of the foregoing and whether or not an option is selected below, this authorization shall expire immediately upon the death of the member. Select one box below:

- ☐ **Valid Until** (MM/DD/YYYY)**:**_____
- ☐ **Valid Indefinitely** (Expires when ETF is notified in writing)

Note: If a box is not checked, this authorization will expire 6 months from the date of signature.

Authorization

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

Section 1 if you are the member authorizing 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 Authorization

My signature on this form confirms that I have had full opportunity to read and consider the contents of this authorization. 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 authorization 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.
- Information disclosed according to this authorization may no longer be protected by federal privacy laws and could be disclosed by the company or individual to whom I have given permission to receive the information.
- A photocopy of this authorization 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 authorization.

Signature	Date

OR

Section 2. Legal Representative Authorization

My signature on this form confirms that I have the proper authority to submit this authorization. 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 authorization 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.
- Information disclosed according to this authorization may no longer be protected by federal privacy laws and could be disclosed by the company or individual to whom I have given permission to receive the information.
- A photocopy of this authorization 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 authorization.

Information About the Legal Representative

I am the (check one): ☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Personal Representative

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 requesting your ETF medical information, contact the ETF Privacy Officer at etfsmbprivacyofficer@etf.wi.gov or 1-877-533-5020.