Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

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

Completion of this form gives the Wisconsin Department of Employee Trust Funds (ETF) 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. Your right to authorize the release of this information comes from a federal privacy law known as the Health Insurance Portability and Accountability Act (HIPAA) and Wis. Stat. § 40.07 (2).

Please Print:

Name *(First, MI, Last):*			
Social Security Number:		**Birthdate:**	
Telephone:			
Street Address:			
City, State and Zip Code:			

What information do you want to release? *(Mark all boxes that apply.)*

☐ Any medical information that may be in my file
☐ Medical information regarding (please list):

_____

Who do you authorize <u>to receive</u> this information?

Name (Person or Entity) _____

*Mailing Address*_____

Relationship to you _____

Describe the reason for the release of information. By explaining the purpose of the request, we are better able to assist you in finding the correct information and documents for you. Please also provide the name of any ETF employee with whom you have been in contact regarding this request. (Optional)

When will this authorization expire? *If no expiration date is provided, this authorization will expire six (6) months from the date signed unless sooner revoked in writing (Wis. Adm. Code § ETF 10.70 (3)).*

Expiration Date: _____
(MM/DD/CCYY)

(Please read and sign the back of this form)

SIGNATURE and ACKNOWLEDGMENT:

I, _____**(print name)**, 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, including medical records and protected health information as described in this form. In addition, I understand the following:

- I may revoke this authorization at any time by sending a signed and dated notice to ETF, but my revocation will not affect any actions ETF or entities which perform contracted services for ETF took before receiving the revocation.
- Payment, enrollment or eligibility for benefits for my health care 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 submitted.

Date (MM/DD/CCYY)	Signature:

If this authorization is signed by a legal representative (for example, parent of a minor, guardian or surviving spouse) on behalf of the individual whose name appears on the first page of this form, please complete the following and provide appropriate documentation:

Representative's Name:_____

Relationship to Individual:_____

If you have any questions, please contact ETF's Privacy Officer toll-free at 1-877-533-5020.

The Department of Employee Trust Funds does not discriminate on the basis of disability in the provision of programs, services or employment. If you are speech, hearing or visually impaired and need assistance, call 1-877-533-5020 or (608) 266-3285 (local Madison). We will try to find another way to get the information to you in a usable form.