WISCONSIN HEALTH FUND
6200 W. BLUEMOUND RD., MILWAUKEE, WISCONSIN 53213, 414-771-5600

AUTHORIZATION FOR DISCLOSURE OF DENTAL INFORMATION

INDIVIDUAL AUTHORIZING RELEASE OF PROTECTED DENTAL INFORMATION

I, _____
Patient Name (Please Print)

_____
Date of Birth

_____
Street Address

_____
City, State, Zip Code

AUTHORIZE _____*WHF*_____TO RELEASE THE FOLLOWING INFORMATION:

*6200 West Bluemound Road*_____
Street Address

*Milwaukee, Wisconsin 53213*_____
City, State, Zip Code

*(414) 755-8325*_____*(414) 475-7386*_____
Phone Number Fax Number

☐ To speak verbally to: _____ regarding my treatment.

In accordance with Wisconsin law that requires special permission to release certain protected information, I,

_____ authorize the release of the following information:

TO THE FOLLOWING PERSON/ ENTITY:

_____
Name of Person/ Entity who should receive the information you want released

PLEASE CONTINUE ON BACK →

FOR THE FOLLOWING PURPOSE:

☐ Continuation of Care ☐ Insurance Eligibility/ Benefits ☐ I elect not to provide a statement of purpose

☐ Other (please specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

You have the right to a copy of this authorization once you have signed it.

You have the right to withdraw this authorization at any time by providing a written statement to Wisconsin Health Fund's Privacy Officer. However, your withdrawal will not be effective until it is received by Wisconsin Health Fund's Privacy Officer and will not be effective in regard to any use/disclosure that Wisconsin Health Fund made prior to receipt of your request to withdraw authorization. If the authorization was obtained to obtain insurance coverage, the law provides the insurer with the right to contest a claim under the policy or to contest the issuance of the policy itself.

You have the right to inspect and copy the health information that is to be disclosed, except for psychotherapy notes, information compiled in reasonable anticipation of a legal proceeding and information subject to the Clinical Laboratory Improvement Amendments of 1988 to the extent that you would be prohibited from accessing the information by law.

You have the right to refuse to sign this authorization. Without your authorization Wisconsin Health Fund cannot release your protected health information except as provided by law. Wisconsin Health Fund may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision not to sign this authorization except 1) Wisconsin Health Fund may condition enrollment in the health plan and eligibility for benefits on providing an authorization which Wisconsin Health Fund requested prior to your enrollment in the health plan if the authorization is not for psychotherapy notes and is sought to determine health plan eligibility, enrollment determinations for you or for Wisconsin Health Fund's underwriting and risk rating determinations; Wisconsin Health Fund may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on your granting an authorization for disclosure of the information to such a third party; 3) for research related treatment.

Re-Disclosure Notice:

The information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by privacy standards established by law.

This information may be sent via fax when necessary.

Expiration Date:

This authorization is valid until _____

(Please provide a valid date or event for expiration of this authorization)

☐ 30 days ☐ 60 days ☐ 1 year

Signature of Person Authorizing Release of Information:

_____ **Date:** _____

Initial of Staff Reviewing/ Accepting Form: _____ ☐ **CHECK ID**