network health
1570 Midway Pl.
Menasha, WI 54952

PERMISSION FOR DISCLOSURE AND USE OF MY PROTECTED HEALTH INFORMATION

There may be times when you may want a spouse, family member or caregiver to have access to your information to help you make decisions. In those cases, we need your permission to share your personal data with those people.

Name _____ Date of Birth 00 / 00 / 0000

Address _____ Member ID _____

Group Number (if applicable) _____ Phone Number _____

I give Network Health permission to disclose any and all protected health information Network Health possesses, including mental health, HIV*, health status and/or substance abuse information to the people listed below. This also includes information on health programs, plan information and caregiver resources.

Name of Person Network Health Can Share My Information With	*Name of Person Network Health Can Share My Information With*
Street Address	*Street Address*
City, State, Zip	*City, State, Zip*
Phone Number	*Phone Number*
Relationship	*Relationship*

Expiration of This Permission

This permission is valid for a **maximum of two years**. It will end either two years from the date this form is signed **or** the date stated below, whichever date comes first. This permission will stay in place for the duration of the time period stated below or until I cancel this permission in writing.

Permission is valid from to .

This form is not complete without your signature.
Please review the information on the back side of this form and sign and date this form.

Information about this document

- I'm giving permission for Network Health to disclose my information to allow the people listed above to help me with my Network Health plan.
- I understand that I have the right to cancel this permission at any time by providing a written statement of cancelation to Network Health. I am aware that my cancelation will not affect the use and/or disclosures of my health information based on this permission before my written cancelation is received.
- I understand that I have the right to review or get a copy of this permission document after I sign it.
- I understand that signing this form is voluntary and that Network Health may not determine treatment, payment, enrollment in a health plan or eligibility for health care benefits based on my decision to sign this document.
- I understand that information used or disclosed based on the permission I'm approving may be disclosed to or received by people/organizations who are not subject to Federal privacy standards, and may be subject to submission to a third party and no longer protected by Federal privacy standards.

**HIV Test Results: I understand my HIV test results may be released without approval based on Wisconsin law, and a list of those people/organizations it may be released to is available upon request.*

I have had an opportunity to review and understand the content of this permission form. By signing this document, I am confirming that it accurately reflects my wishes.

SIGNATURE _____ **DATE** 00 / 00 / 0000

☐ Check here if you are the member's Legal Representative (must attach copies of authorization as required by law)

_____ _____

Relationship Authority

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