AUTHORIZATION FORM
To Permit Use and Disclosure of Protected Health Information

PURPOSE OF THIS FORM: This Authorization Form is to be used when an individual wishes to give another person access to his or her health information. When completed, it will allow WPS Health Plan, Inc. dba Arise Health Plan (Arise), a wholly owned subsidiary of Wisconsin Physicians Service Ins. Co., to disclose your health information to, and receive it from, the person(s) stated on the form.

Section 1. Individual to Whom This Form Pertains

Please provide the following information to identify the individual who is the subject of the information to be used or disclosed. This will generally be yourself, unless you are the Personal Representative of the individual. Parents are generally considered the Personal Representative of their minor dependents(s).

Name: _____

Address: _____

City, State, Zip code: _____

Date of Birth: _____Arise Subscriber Number: _____

Home Telephone: _____Work Telephone_____

Section 2. Information to Be Used or Disclosed

Check one box to describe the health information you are authorizing to be used or disclosed:

☐ ALL – Check if you wish to have *all* of your health information disclosed to the person(s) named in Section 5 or to Arise, or:

☐ SPECIFIC – Check if you wish to have only the following *specific* health information about you disclosed (*must write in the specific information*):

_____

_____

Section 3. Purpose of the Use or Disclosure

Check one box to indicate the purpose of the requested use or disclosure of your health information:

☐ Check if the disclosure is "at the request of the individual" (or individual's Personal Representative), or:

☐ Check if the disclosure is only for the following specific purposes (*must write in the specific purposes*):

_____

_____

Section 4. Persons Authorized to Disclose Your Health Information

By completing and signing this Authorization Form, you are authorizing Arise to *disclose* your health information for the purposes provided under Section 3. If you wish to authorize other persons or organizations to disclose your health information in addition to Arise (such as a doctor, hospital, insurance company, etc.), then check the box:

☐ Check to authorize the following persons or organizations to *disclose* your health information (must write in the specific persons/organizations):

_____

Section 5. Persons Authorized to Receive Your Health Information

By completing and signing this Authorization Form, you are authorizing Arise to *receive* your health information for the purposes provided under Section 3. If you wish to authorize other persons or organizations to receive your health information in addition to Arise (such as a friend, spouse, family member, attorney, doctor, insurance company, etc.), then check the box:

☐ Check to authorize the following persons or organizations to *receive* your health information (must write in the specific persons/organizations):

_____

Section 6. Revocation and Signature

I understand that I have the right to revoke this authorization at any time by providing a written statement of revocation to Arise. I am aware that my revocation will not be effective until received by Arise and will not be effective regarding the uses and/or disclosures of my health information that Arise has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides Arise with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this form and that Arise may not condition payment, health plan enrollment or benefits eligibility on my decision to sign this authorization, unless this authorization is being sought for determinations of health plan enrollment, eligibility, underwriting, and/or risk rating. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws and could be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records.

This authorization will expire the earlier of the following: 30 months from the date signed, or on

_____

-Indicate date, or an event that relates to you (the Customer) or the purpose of the authorization-

Signature of You or Your Personal Representative
Please print name: Date:
IF SIGNED BY A PERSONAL REPRESENTATIVE, DESCRIBE REPRESENTTIVE'S AUTHORITY TO ACT ON BEHALF OF THE CUSTOMER (ATTACH ANY APPLICABLE PROOF, SUCH AS GUARDIANSHIP OR POWER OF ATTORY DOCUMENTS): _____