AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION, and
TREATMENT OR PATIENT HEALTH CARE RECORDS

TO: Wisconsin Department of Health Services (DHS); c/o HMS, Inc

WI DHS c/o HMS INC
CASE MGMT DEPT –WI
5615 HIGH POINT DR
IRVING TX 75038-2453

Under 45 C.F.R. § 164.508, and Wis. Stat. §§ 51.30 and 146.82, I hereby authorize the below-named entity, or its authorized agent, to release and disclose protected health information (PHI), treatment and patient health care records to the above-named entity. In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information; I also authorize the release of records pertaining to [Check all that apply]:

- ❑ Mental Health and/or Developmental Disabilities
- ❑ HIV or AIDS
- ❑ Alcohol and/or Drug Abuse

____
Name of organization / covered entity authorized to release PHI, treatment and patient health care records

Address: ________________________________
____
____
City, State, ZIP+4 code

Individual / Patient's Name: ____

Address: ________________________________
____
____
City, State, ZIP+4 code

DOB: ☐ ☐ / ☐ ☐ / ☐ ☐ ☐ ☐ SSN: ☐ ☐ ☐ - ☐ ☐ - ☐ ☐ ☐ ☐
(MM/DD/YYYY)

Health Plan Member ID Number: ____

I understand this medical information may be used by the person or entity I authorize to receive this information for the purposes of handling the subrogation of my case or other purposes as I may direct.

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I understand that I have the right to revoke this authorization at any time, in writing and provide it to the entity I authorized to release information. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that this authorization for release shall be in force and effect until my claim or case is closed or such time as I revoke this authorization in writing.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be redisclosed by the recipient of the records only if allowed by law and may no longer be protected by federal or state law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.

I understand that I have a right to inspect and, upon paying any applicable fees, obtain a copy of any of the records disclosed under this authorization.

____
Printed Name of individual/patient or authorized representative

____
Signature of individual/patient or authorized representative

____
Relationship to individual/patient if signed by authorized representative

Date: ________________________