COMMON GROUND
HEALTHCARE COOPERATIVE

CGHC Claims and Correspondence
PO Box 1630
Brookfield, WI 53008-1630
877-514-2442

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

I: MEMBER INFORMATION

Member Last Name	Member First Name	MI	Member Date of Birth

Member Street Address	City	State	ZIP Code

Daytime Telephone Number (with area code)	Identification Number (See ID Card)	Group Number (If applicable, see ID card)

II: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following people or company(ies) have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

❍ My Spouse (First and Last Name)	❍ My Parents (If you are over 18 – First and Last Name[s])
❍ My Domestic Partner (First and Last Name)	❍ My Insurance Broker/Agent(Name of Company, First and Last Name)
❍ My Adult Child(ren) (First and Last Name[s])	❍ Other (First and Last Name, Company, and relation to you)

III: PURPOSE OR NEED FOR DISCLOSURE (Check applicable categories.)

❍ Transferring or Continued Medical Care (Customary to release last two (2) years of information. Release may occur electronically.)
❍ Personal Use ❍ Insurance Eligibility/Benefit ❍ Disability Determination ❍ Legal Investigation
❍ Upcoming Appointment Date: _____ ❍ Other (Please specify): _____

IV: HEALTH INFORMATION TO BE RELEASED

❍ **All my information.** This can include health, a diagnosis (name of illness/condition), claims, doctors and other healthcare providers and financial information (e.g., billing and banking). This doesn't include sensitive information (*see below) unless it is approved below.
Office Visits: ❍ Primary Care ❍ Speciality (Specify): _____ ❍ Procedures
❍ Immunization Records ❍ Lab Reports ❍ X-ray Reports ❍ X-ray Films ❍ Billing Records
❍ Specific information related to: _____
❍ For the following date(s) or timeframe: From _____/_____/_____ (MM/DD/YYYY) To _____/_____/_____
*Federal and state laws require special permission to release certain information. Please check if these records should be released:
❍ Mental Health ❍ Alcohol and/or Drug Abuse ❍ HIV/AIDS Test Results ❍ Developmental Disabilities

V: EXPIRATION

This authorization will expire on _____/_____/_____ (MM/DD/YYYY). If I do not indicate a date, this Authorization will expire one (1) year from the date of my signature below. A photocopy of this authorization is as valid as the original.

VI: SIGNATURE

I have read the contents of this form. I understand, agree, and allow Common Ground Healthcare Cooperative (CGHC) to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that CGHC does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to CGHC. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Signature: _____ Date: _____

If this Authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____ Relationship to Member: _____