Group Health Cooperative
of South Central Wisconsin

Medical Billing Department
1265 John Q. Hammons Drive
Madison, WI 53744-4971

Direct Phone: (608) 251-4138
Fax: (608) 828-4856
www.ghcscw.com

# AUTHORIZATION TO RELEASE PAYMENT INFORMATION

_____ _____ _____ _____ _____
Patient Last Name (print) Patient First Name (print) GHC# Daytime Phone Date of Birth

**AUTHORIZE DISCLOSURE FROM:**

Group Health Cooperative of South Central Wisconsin
Attention: Medical Billing Department
1265 John Q. Hammons Drive
Madison, WI 53744-4971

**TO RELEASE PAYMENT INFORMATION TO:**

_____
Organization or Individual

_____
Street Address

_____
City State Zip

**PURPOSE OF DISCLOSURE**:

_____ Personal Use _____ Payment of Claim

_____ Legal Investigation _____ Other (describe):

**INFORMATION TO BE DISCLOSED:**

_____ Office Co-Pay

_____ Pharmacy or Medication Co-Pay Information

_____ Other (describe):_____

**DATE RANGE**: _____to_____

**YOUR RIGHTS REGARDING THIS AUTHORIZATION:**

1. Right to inspect or receive copy of information used or disclosed.
2. Right to receive a copy of this information.
3. Right to refuse to sign this authorization.
4. Right to withdraw or revoke this authorization.
5. Understanding that if authorizing this information to another person or organization, it may not be subject to privacy regulations.

**EXPIRATION DATE**

This authorization is effective until_____ *(If no date is indicated, this authorization will be effective for a period of one (1) year from the date signed by the patient).*

**DISCLOSURES REQUIRING SPECIAL CONSENT**

My signature below also specifically authorizes the release of payment information related to AIDS/HIV, mental health care and treatment, alcohol or drug use/treatment and developmental disabilities.

**SIGNATURE**

_____ _____
Signature of Patient or Parent/Guardian Date of Signature

Send completed form to Group Health Cooperative of South Central Wisconsin, Medical Billing Department, 1265 John Q. Hammons Drive, Madison, WI 53744-4971