



Health Insurance Risk-Sharing Plan
 1751 W. Broadway – P.O. Box 8961 – Madison, WI 53708-8961
 (800) 828-4777 or (608) 221-4551

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 HIRSP to disclose your health information to, and receive it from, the person(s) stated on the form.

Your Name: _____ **Your Date of Birth:** ____/____/____
 Month Day Year

Your Address: _____

HIRSP Member Number: _____ **Telephone:** _____

Section 1. Please provide the name of the persons or organizations that you are authorizing to receive your Protected Health Information from HIRSP.

Name: _____ Date of Birth: _____

Address: _____

Relationship: ___ Spouse ___ Child ___ Parent ___ Other _____

(If the person identified is a Power of Attorney (POA) or other legal representative who has paper work identifying their health care and insurance decision-making abilities on your behalf, please submit a copy of that paperwork along with this completed form to HIRSP for review.)

Section 2. Information To Be Used or Disclosed - REQUIRED SECTION

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

- ALL – Check if you wish to have all your health information disclosed to the person(s) named in Section 1 or to HIRSP, or :
- SPECIFIC – Check if you wish to have only the following specific health information about you disclosed to the person(s) named in Section 1 or to HIRSP (must write in specific information):

Section 3. Purpose Of The Use or Disclosure – REQUIRED SECTION

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):

For more information about HIRSP, visit our Web site at: www.hirsp.org

Section 4. Expiration and Revocation

Expiration: This authorization will expire as follows (complete one):

- On _____/_____/_____(MM/DD/YYYY)
- On occurrence of the following event (which must relate to the Member or to the purpose of the use or the disclosure being authorized.) _____

Right to Revoke: I understand that I may revoke all or part of this authorization at any time by giving written notice of my revocation to the Privacy Office information listed below. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before receiving my written notice of revocation.

HIRSP
Customer Services
PO Box 8961
Madison, WI 53708-8961

Section 5. Signatures

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to HIRSP. I understand that by signing this form, I am confirming my authorization that HIRSP may use or disclose to the person or organizations named in this form the health information described in this form. I also understand that HIRSP will not condition payment, enrollment, or eligibility for benefits in HIRSP on the signing of this authorization.

I understand that once the 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.

Signature – Member

Date

If this authorization is signed by a personal representative on behalf of the member, provide a copy of the documentation to support the representation and complete the following:

Print Name of Personal Representative

Relationship to Member

Signature – Personal Representative

Date signed

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