Authorization for Release of Health Information

Member's Full Name: _____ **Date of Birth:** _____

Member or Subscriber ID #:_____

Member's Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

I understand and agree that:

- This authorization is voluntary;
- My health records may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying Trilogy Health Insurance in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Who May Receive and Disclose my Information:

I authorize Trilogy Health Insurance and its partners to receive from or disclose my health information to the following person(s) or organization(s):

_____
(Full Name of Person(s) or Organization(s))

_____
(Full Address of Person(s) or Organization(s))

Type of Information to be Disclosed:

- I authorize disclosure of all my health information including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; or

- I authorize only the disclosure of the following information:

_____
(Type of Information)

Purpose of Disclosure:

- My health information is being disclosed at my request or at the request of my personal representative; or

- My health information is being disclosed for the following purpose:

_____
(Explain Purpose)

_____ _____
Signature of Member Date

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member and complete the following:

Guardian or Representative:

Name: _____ **Phone Number:** _____

Street Address: _____ **City:** _____**State:**_____

Zip Code: _____

_____ _____
Signature of Guardian or Representative **Date**

PLEASE MAINTAIN A COPY OF THIS FORM FOR YOUR RECORDS AND RETURN IT TO:

Trilogy Health Insurance
18000 W Sarah Lane Ste 310
Brookfield WI 53045

Interpreter Services:

For help to translate or understand this, please call 1-855-530-6790 or (TTY) 1-414-755-3619

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono 1-855-530-6790 o (TTY) 1-414-755-3619

Если вам не всё понятно в этом документе, позвоните по телефону 1-855-530-6790 or (TTY) 1-414-755-3619

Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-855-530-6790 or (TTY) 1-414-755-3619

Translating or interpreting services are available for those who need them.

This service is provided free of charge.

Phone: 414-755-3619 or 855-530-6790