patientcare
we make sense

+Authorization for Disclosure of Protected Health Information by Providers and Payers

This form is used for a Patient Care member to authorize providers and payers to disclose the member's protected health information. Information to be disclosed may include complete health record(s), photographs, videotapes, x-rays, digital and other images; all claim information and genetic health information. This health information may also include information relating to AIDS or HIV, psychiatric care, treatment for alcohol and/or drug abuse and genetics.

You may restrict the information to be disclosed by indicating below the protected health information that you want handled in a restricted manner and the restriction you want applied:

_____

SECTION A: PATIENT INFORMATION

Name: _____

Date of Birth: _____

Social Security No: _____

Insurance Id No: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Email: _____

Employer's Name **Northern School District Trust**

SECTION B: AUTHORIZED RECIPIENT(S) (Person who will receive your information)

Patient Care Advocates
Labyrinth HealthCare Group
633 W. Wisconsin Ave, Ste. 1310
Milwaukee, WI 53203
(866) 253-2273 Fax: (414) 271-1795

Authorized dates of service: ☐ All dates of service

Expiration: This authorization will automatically expire upon termination of membership in Patient Care.

Right to Revoke: You may revoke this authorization at any time, except to the extent that action or release has been taken in reliance on this authorization, by giving written notice to the address listed at the bottom of this page.

This information is to be disclosed to Labyrinth HealthCare Group (LHG) for the purpose of assisting me in optimizing my health care. I hereby authorize any and all hospitals, insurance carriers, physicians, clinics, health plans, health clearing houses, medical organizations, or other health or allied health person or entities, to consult with and to provide and make available to LHG, its agents and employees, any and all health information and health records that may be requested by LHG. This information may include, but is not limited to, billing charges, insurance coverage, eligibility, coverage decisions, laboratory and radiology studies/results, even if otherwise privileged or confidential. I agree LHG may release all such information on a need to know basis to all providers, administrators, and affiliates in order to resolve the issue being addressed. When the information is used or disclosed pursuant to the authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by this rule.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Signature: **X**_____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following and attach legal documentation of Legal Guardian or Holder of Power of Attorney:

Personal Representative's Name: _____

Relationship to Patient: _____

Please complete and return this form to:

Patient Care Privacy Office
633 W. Wisconsin Ave, Ste 1310
Milwaukee, WI 53203
Fax: (414) 271-1795