

Member Requested Authorization for Release of Information

Please read these instructions carefully before completing the form on the back.

When to Use This Form

You must complete this form if you want Group Health Plan and Pierce County to give information about you to someone else (for example: Insurance Coordinator or family member).

Parents or a legal guardian may sign for a minor unless the information being released is about:

- Pregnancy
- Sexually transmitted disease
- Alcohol or drug abuse
- Abortion
- Hepatitis B shot
- Mental illness of a minor

For these types of records, the minor must sign the authorization.

How to Complete This Form

The Authorization for Release of Information form must be completed and signed by:

- The person whose information will be released or,
- The parent or legal guardian of a minor whose information will be released except as listed above or,
- The personal representative of the person whose information will be released (ex: power of attorney, conservator, legal guardian, executor).

To complete this form:

- Fill in the name, member identification and date of birth of the person whose information will be released.
- Check the type(s) of information you want us to release.
- Fill in the name and address of the person or group who will receive the information.
- State the purpose for this authorization unless it is at the request of the Member or the Member's Personal Representative.
- Sign and date the form.
- If you are not the person whose record will be released, state your relationship to that person.

Mail or Fax this form to:

Pierce County	FAX:715-273-6853
PO Box 119	
Ellsworth, WI 54011	
OR	
CCS/tpa	FAX:651-662-2159
Atrium	FAX:715-386-8326

Note: Under the law, an authorization for use or disclosure of psychotherapy notes cannot be combined with an authorization for use or disclosure of other health care information.