

Health Tradition

A Mayo Health System Choice in Wisconsin

Date:

Dear Member:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows covered entities to use and disclose protected health information for purposes of treatment, payment or operations without specific authorization from our insured members. Wisconsin Statute 610.70(2) requires us to have authorizations to access individuals' protected health information under certain circumstances.

This authorization allows access and use of protected health information in order to perform routine functions such as payment of claims for health care services, requests for and evaluation of benefits or services, administration of the plan, or to conduct utilization review, case management and quality improvement activities. In order for Health Tradition Health Plan to continue to provide the same level of service without additional delays, we are required to have this authorization from you.

Please sign and return the enclosed authorization form in the envelope provided within 5 days. This authorization will be in force for the life of your policy with us. Without this signed authorization in place, Health Tradition Health Plan will not be able to pay claims for your health care. Decisions regarding referrals for additional services could also be delayed. Important points about this authorization are:

- **Every health plan member, including spouse, over the age of 18 must sign a separate authorization form.**
- **Your health care claims cannot be paid without this authorization in place.**
- **This authorization will be renewed should you leave the Plan and re-enroll.**
- **A Notice of Privacy Practice is published in your policy documents and is on our website: www.healthtradition.com.**

If you have any questions about this authorization form, please call our Customer Service line at 1-877-832-1823.

Steven M. Kunes
Executive Director
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Enclosure

Health Tradition

A Mayo Health System Choice in Wisconsin

Date: ____/____/____

Member Name: _____ Member Number: XXXXX__/_/_/_/_/_

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Health Tradition Health Plan (HTHP) administers your company's health care benefits and is in the process of updating its records regarding authorization for other parties to disclose your medical information. Please sign and return this form in the enclosed envelope. Failure to return this form will result in the denial of your medical claims.

I. Protect Health Information

By signing this form, I authorize HTHP to use or disclose my protected health information as stated in their Notice of Privacy Practices. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records and alcohol and/or drug abuse records. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes or the disclosure of information concerning whether I or my dependent child(ren) have obtained a test for the presence of HIV antigen or nonantigenic products of HIV or an antibody to HIV or what the results of this test were.

II. Purpose of this Authorization Form

By signing this form, I authorize the use and disclosure of protected health information as necessary for the provision or evaluation of benefits or services, the payment of claims or requests for service or benefits, or administration of the plan, or to allow the insurer to conduct utilization review, case management and quality improvement activities.

III. Entities Authorized to Use and Disclose My Protected Health Information

I hereby authorize HTHP, their reinsurers, and their legal representatives ("Insurers") to receive, use, and disclose my protected health information for the Purpose listed above.

I authorize the Insurers to disclose my protected health information: between themselves, to reinsuring companies, insurance intermediaries, or other persons or organizations performing business or legal services only in connection with the Purpose above as stated in the Notice of Privacy Practices.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, or third party administrator that has any record or knowledge of me or my dependent child(ren) to give to HTHP any and all protected health information concerning diagnosis, treatment and prognosis for any physical or mental condition including, but not limited to, all medical and health care records, but not including whether I obtained a test for the presence of HIV antigen or nonantigenic products of HIV or what the results of this test were or psychotherapy notes.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws. See Notice of Privacy Practices.

IV. Term of Authorization

I agree this Authorization shall be valid from the date below for the term of my policy or the pendency of a claim under the policy, whichever is longer.

V. Right to Revoke

I understand I may revoke this authorization at any time by giving advance written notice to HTHP. Revocation of this authorization form will not affect actions HTHP or others took in reliance on this form prior to the written notice of revocation.

I have had full opportunity to read and consider this form. I understand that, by signing this form, I authorize the uses and disclosures of protected health information described in this form. I understand that I may only revoke authorization for myself or my minor child(ren) consistent with state law.

Signature of Adult Member / Date

Printed Name of Member

Signature of Authorized Representative