

HEALTH TRADITION HEALTH PLAN

P.O. Box 188 La Crosse, WI 54602-0188
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR USE IN APPEALS AND GRIEVANCES

I hereby authorize Health Tradition Health Plan, Operations Department to disclose to my Authorized Representative, _____ information from my health care records that apply to my appeal. This includes information from _____
Name
to _____
Date

I understand that the specific type of information to be disclosed includes the following and this information may not be redisclosed:

- Medical history, diagnostic, and therapeutic information, or
- Drug information, or
- The following information only: _____

I authorized this information to be released to:

- An Authorized Representative, so designated in writing unless exemptions apply
- A provider, acting as my Authorized Representative
- Another payor, such as a secondary or primary insurance company or government program

Patient must initial for release of information as indicated:

Patient

Initials _____ I also authorize the following persons access to my HIV antibody test results.

Patient

Initials _____ I also authorize the following person or agencies access to my mental health and/or chemical dependency records.

I understand that the purpose or need for this information is for:

- To investigate and process an appeal/grievance
- To aid in claim payment/referral determination.
- To process a request for an Independent External Review
- Other (please specify) _____

This release prohibits further use of this information without additional consent.

I also understand that this authorization is revocable. Unless revoked, it will expire 90 days from the date of signature. Date of Expiration ____/____/____

Member Name _____

Date of Birth ____/____/____ Insurance ID #: _____

Member Address _____

Maiden or Previous Name (s) _____

Signature of member Date ____/____/____

Person Authorized by Member

Signature of Authorized Representative Date ____/____/____

Authorized Representative's relationship to Member