Authorization for Disclosure of Protected Health Information by Providers and Payers

DirectPath
To Reduce Health Care Costs

This form is used for you, as a recipient of DirectPath advocacy services through your employer, to authorize providers and payers to disclose your 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

EMPLOYER		ADDRESS	
NAME		CITY	
DATE OF BIRTH		STATE	ZIP
INSURANCE ID#		PHONE#	
SSN #		EMAIL	

SECTION B: AUTHORIZED RECIPIENT(S)*(PERSON WHO WILL RECEIVE YOUR INFORMATION)*

DirectPath Advocates
633 W. Wisconsin Ave Suite 1310
Milwaukee, WI 53203
Phone: (866) 253-2273 | Fax: (414) 271-1795

Authorized dates of service: ☐ All dates of services **Date Range:** From _____ To _____

Expiration: This authorization will automatically expire when you are no longer eligible to receive DirectPath advocacy services through your employer.

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 DirectPath for the purpose of providing advocacy services to me. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether or not I sign this authorization. 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 DirectPath, its agents and employees, any and all health information and health records that may be requested by DirectPath. 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 DirectPath 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 federal or state law.

SIGNATURE: _____ **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:	

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:

Please retain a copy for your records, and a copy can be provided to you by DirectPath upon request.

Please complete and return this form to: DirectPath Privacy Office
633 W. Wisconsin Ave Suite 1310
Milwaukee, WI 53203
Fax: (414) 271-1795