CGHC Claims and Correspondence
PO Box 1630
Brookfield, WI 53008-1630
1-877-514-CGHC (2442)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

I: MEMBER INFORMATION

Member Last Name	Member First Name	MI	Member Date of Birth
Member Street Address	City	State	ZIP Code

Daytime Telephone Number (with area code)	Identification Number (See ID Card)	Group Number (If applicable, see ID card)

II: PERSON(S) OR COMPANY WHO WILL RECEIVE THIS INFORMATION

I authorize the following person(s) or company(ies) to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

❍ My Spouse (First and Last Name)	❍ My Parents (If you are over 18 – First and Last Name[s])
❍ My Domestic Partner (First and Last Name)	❍ My Insurance Broker/Agent(Name of Company, First and Last Name)
❍ My Adult Child(ren) (First and Last Name[s])	❍ Other (First and Last Name, Company, and relation to you)

III: PURPOSE OR NEED FOR DISCLOSURE (Check applicable categories.)

❍ Transferring or Continued Medical Care (Customary to release last two (2) years of information. Release may occur electronically.)
❍ Personal Use ❍ Insurance Eligibility/Benefit ❍ Disability Determination ❍ Legal Investigation
❍ Upcoming Appointment Date: ______________________ ❍ Other (Please specify): ______________________________________

IV: HEALTH INFORMATION TO BE RELEASED (Check applicable categories.)

❍ **All my information.** This can include health, a diagnosis (name of illness/condition), claims, doctors and other healthcare providers and financial information (e.g., billing). This doesn't include sensitive information (*see below) unless it is approved below.
Office Visits: ❍ Primary Care ❍ Speciality (Specify): ____________________________ ❍ Procedures
❍ Immunization Records ❍ Lab Reports ❍ X-ray Reports ❍ X-ray Films ❍ Billing Records
❍ Specific information related to: ______________________
❍ For the following date(s) or timeframe: From ________/________/________ (MM/DD/YYYY) To ________/________/________
*Federal and state laws require special permission to release certain information. Please check if these records should be released:
❍ Mental Health ❍ Alcohol and/or Drug Abuse ❍ HIV/AIDS Test Results ❍ Developmental Disabilities

V: EXPIRATION

This authorization will expire on ________/________/________ (MM/DD/YYYY). If I do not indicate a date, this Authorization will expire when my enrollment in Common Ground Healthcare Cooperative expires. A photocopy of this authorization is as valid as the original.

VI: SIGNATURE

I have read the contents of this form. I understand, agree, and allow Common Ground Healthcare Cooperative (CGHC) to release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that this information may be released electronically.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to CGHC. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Signature: ____ Date: ____________________

If this Authorization is signed by a legal representative on behalf of the patient, complete the following:

Legal Representative's Name: ______________________________ Relationship to Member: ____________________

NOTICE OF NON-DISCRIMINATION AND AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

Common Ground Healthcare Cooperative (CGHC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). This means that CGHC does not exclude people or treat them differently because of race, color, national origin (including limited English proficiency and primary language), age, disability, sex (including pregnancy, sexual orientation, gender identity, and sex characteristics).

CGHC provides free aids and services to people with disabilities so they may communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, and other formats)

CGHC provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please contact the CGHC Civil Rights Coordinator.

If you believe that CGHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). You can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone.

CGHC Civil Rights Coordinator
Phone Number: 414.269.4684 (TTY: 711)
Fax Number: 262.754.9690
Email: CivilRights@CommonGroundHealthcare.org
Mail: PO Box 1630
Brookfield, WI 53008-1630

U.S. Department of Health and Human Services
Phone: 1.800.368.1019 (TDD: 1.800.537.7697)
Mail: 200 Independence Avenue SW,
Room 509F, HHH Building
Washington, DC 20201
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1.877.514.2442 (TTY/TDD: 711)	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.514.2442 (TTY/TDD: 711)	**Chinese** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.877.514.2442 (TTY/TDD: 711)
Hmong LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.877.514.2442 (TTY/TDD: 711)	**Vietnamese** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.514.2442 (TTY/TDD: 711)	**Arabic** ةظوحلم: اذإ تنك ثدحتت ركذا ةغللا، نإف تامدخ ةدعاسملا ةيوغللا (TTY/TDD: 711) 1.877.514.2442 مقرب لصتا .ناجملاب كل رفاوتت
Pennsylvania Dutch Wann du [Deitsch] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.877.514.2442 (TTY/TDD: 711)	**Russian** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.514.2442 (телетайп: 711)	**Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.514.2442 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.514.2442 (TTY/TDD: 711).	**Thai** ี ยน: ถา้ คุณพดภาษาไทยคุณสามารถใชบ้ รการชว่ ยเหลอื ทางภาษาไดฟ้ ร โทร 1.877.514.2442 (TTY/TDD: 711).	**Laotian** ໂປດຊາບ: ຖ້ າວ່ າ ທ່ ານເວົ້ າພາສາ ລາວ, ການບໍລິການຊ່ ວຍເຫຼືອ ດ້ ານພາສາ, ໂດຍບໍ່ເສັ ຽຄ່ າ, ແມ່ ນມີພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1.877.514.2442 (TTY/TDD: 711)
Hindi धयान द : य द आप �हंद� बोलते ह तो आपके िलए मु त म भाषा सहायता सेवाएं उपलबध ह । 1.877.514.2442. पर कॉल कर । (TTY/TDD:711)	**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.877.514.2442 (TTY/TDD: 711).	**Albanian** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.877.514.2442. (TTY/TDD: 711)

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