



1717 W. Broadway • P.O. Box 8190 • Madison, WI • 53708-8190



THE EPIC LIFE INSURANCE COMPANY
A WPS Company

AUTHORIZATION TO PERMIT DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE COMPLETE ALL APPROPRIATE GRAY AREAS ON THIS FORM. SEE PAGE TWO (2) FOR INSTRUCTIONS.

Your Name: _____ Your Birth Date: _____ / _____ / _____
MONTH DAY YEAR

Your Address: _____

Insurance Policyholder's Name: _____

WPS Customer Number: _____ Telephone: _____

SECTION 1. Please provide the name of the persons or organizations that you are authorizing to receive your Protected Health Information from WPS.

_____	Relationship to you (check one)
Name	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent
Date of Birth	<input type="checkbox"/> Child
	<input type="checkbox"/> Other _____

Note-If a person listed is a Power of Attorney (POA) or other legal representatives, see reverse side for further instructions.

SECTION 2a. Please check a box to indicate the INFORMATION to be disclosed.

ALL - Check this box if you wish to have all information disclosed to the individual identified in SECTION 1 above.
OR
 SPECIFIC – Check if you wish to have only the following specific health information about you disclosed (must fill in):

SECTION 2b. Please check this box to indicate the PURPOSE of the disclosure of your health information.

Check if the disclosure is "at the request of the individual" (or the individual's personal representative).
OR
 Check if the disclosure is only for the following SPECIFIC purpose listed below (must write in the specific purposes):

SECTION 3. I understand that I have the right to revoke this authorization at any time by providing a written statement of revocation to WPS. I am aware that my revocation will not be effective until received by WPS and will not be effective regarding the uses and/or disclosures of my health information that WPS has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides WPS with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this form and that WPS may not condition payment, health plan enrollment or benefits eligibility on my decision to sign this authorization unless this authorization is being sought for determinations of health plan enrollment, eligibility, underwriting, and/or risk rating. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy regulations and could be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records.

SECTION 4. This authorization will expire 30 MONTHS from the date signed. If you want this authorization to expire prior to the 30-month limit, please indicate an expiration date or an event that relates to you (the customer), or the purpose of this authorization:

Signature of You or Your Personal Representative: _____

Please print name: _____ Date: _____

(If signed by Your Personal Representative, please see page two (2) for additional instructions.)

About this form and who fills it out:

This Authorization Form is to be used when an individual wishes to give another person access to his or her health information. When completed, it will allow WPS to disclose your health information to the person(s) stated on the form. Your health information is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), State Laws, and the privacy policies and procedures at WPS.

- SECTION 1. The information completed in this section tells us to whom you want the information released. If the person identified is a Power of Attorney (POA) or other legal representative who has paperwork identifying their health care decision-making abilities on your behalf, please submit a copy of that paperwork, along with this completed form to WPS for review.
- SECTION 2a & 2b. In this section, you tell us what information you wish to be released (2a) and the purpose of the disclosure (2b). You may choose to have **all** of your protected health information released to the person named in Section 1., or if you choose not to release all information, then you must **specify** with a written description the information to be disclosed to the designated individual.
- SECTION 3. This section outlines your rights regarding this form. Please read thoroughly.
- SECTION 4. This authorization form will expire in **30 months from the date signed**. **If you want this form to naturally expire, please skip to the signature portion of this form. If you want this authorization to expire prior to the 30-month limit, please indicate date, or an event that relates to you, the customer, or the purpose of this authorization.**

After completing this form, please send it back to us.

Fax the form to us at: 608-223-3626

**Or mail the form to us at: WPS MEMBER SERVICES
PO BOX 8688
MADISON WI 53708-8688**