



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



THE EPIC LIFE INSURANCE COMPANY

A WPS Company

## AUTHORIZATION To Permit Use and Disclosure of Health Information

Patient Name: \_\_\_\_\_ Customer Number: \_\_\_\_\_

**I hereby authorize the following use or disclosure of my protected health information by or to Wisconsin Physicians Service Insurance Corp. ("WPS"):**

Specific *description* of information to be used or disclosed: Medical Records and office visit notes

Specific *purpose* of the use or disclosure: Underwriting and for the purpose of creating an insurance policy

Person/organization authorized to *receive* the information: Wisconsin Physicians Service Insurance Corporation (WPS)

Person/organization authorized to *disclose* the information to WPS:

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.

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.

I understand that a photocopy or facsimile of this authorization is as effective as the original.

This authorization will expire the earlier of the following: 30 months from the date signed, or on \_\_\_\_\_.

*-Indicate date, or an event that relates to you (the Customer) or the purpose of the authorization-*

Signature of Patient or Patient's Personal Representative:	
Please print name:	Date:
If signed by Patient's Personal Representative, describe Representative's authority to act on behalf of the Customer: _____	