



GENERAL AUTHORIZATION

Purpose: A General Authorization is used when you want to give someone other than yourself or Unity permission to hear about, get a paper copy of, or use your protected health information. A General Authorization is not necessary for us to conduct our routine business of processing your claims. A General Authorization is appropriate if you wish to designate someone other than yourself to regularly discuss your health claims with us (such as your son or daughter, or an insurance agent), or you wish us to release your protected health information to someone other than yourself, for example, another insurance company.

SECTION A: Psychotherapy notes

Psychotherapy Notes are the provider's handwritten mental impressions of a patient session and are not part of the medical record. These notes must be authorized independent of any other authorization. This box should be checked *only if you are requesting the release of your psychotherapy notes.*

Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

SECTION B: Individual authorizing use and/or disclosure

This section is used to identify the individual who is the subject of the information to be released, usually yourself. (If you are a parent, you must also authorize release of protected health information for your minor child.)

Name: _____

Member Number: _____

Address: _____

Date of Birth: _____

Telephone Number: _____

Email Address: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

Effect of Granting this Authorization: Health insurers and health care providers are subject to the federal privacy rules. I understand that if the person or organization I authorize to receive the protected health information is **not** a health insurer or health care provider, the person or organization may further disclose the protected health information. In such case, the health information is no longer protected by the federal privacy rules.

SECTION C: The use and/or disclosure being authorized

Specific purpose of the use or disclosure. The purpose of this authorization states why you are giving this authorization. Please indicate either "at the request of the individual" or write in the specific purpose(s) in the space provided. Examples of a specific purpose: "*To allow my adult son, John Smith, to discuss my health insurance claims with Unity Health Insurance.*"

At request of individual (or the individual's personal representative)

For the following purposes: _____

Specific description of information to be used and/or disclosed. This is the information you are authorizing to be released. Example: "*All claims and benefit information for my hospital stay in February 2003.*"

Person/Organizations authorized to provide the information. This could be a provider, clinic, hospital and/or health insurance company. Examples: "*Unity Health Insurance*" or "*University of Wisconsin Hospital and Clinics.*"

Person/Organizations authorized to receive the information. Please provide the full name of the person (or other means to identify) or business you want to receive the information you are authorizing for release. Examples: "Clara Smith, wife," or "XYZ Auto Insurance."

SECTION D: Expiration and revocation

Please fill in the date or the event upon which this authorization will expire. Without an expiration date or event, this authorization will not be valid.

There are two situations where the duration of the authorization is mandated by Wisconsin law:

- ◆ If the authorization is for obtaining information in connection with an insurance policy application, an insurance policy reinstatement, or a request for a change in policy benefits, the authorization cannot last longer than 30 months from the date the authorization is signed.
- ◆ If the authorization is for obtaining information in connection with a claim for benefits under an insurance policy, the authorization duration may not exceed the policy term or the pendency of the claim for benefits, whichever is longer.

Expiration: This authorization will expire (complete one):

- On ____/____/_____
- On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): _____

Right to Revoke: You can revoke only your own authorization. You may revoke this authorization at any time by giving written notice of revocation to Unity's Privacy Official. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation.

Unity Privacy Official
840 Carolina Street, Sauk City, WI 53583
Telephone: 1-800-362-3308

Email: privacy.official@unityhealth.com
Fax: 608-643-1450

SECTION E: Individual's signature

To be valid, the authorization must be signed and dated by the person listed in section B. Parents must sign the authorization to authorize release of health information on their minor child(ren), with some exceptions. If a person's personal representative (such as a parent, guardian or power of attorney) signs this form, the representative must also include his/her name and relationship to the person listed in section B.

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____
Personal Representative's Name: _____
Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

FOR OFFICE USE ONLY:
Upon Receipt, Forward to Unity's Privacy Coordinator
Reviewed (date/initials): _____
Entered in Phone Log (date/initials): _____
Scanned (date/initials): _____
Filed (date/initials): _____