COMMON GROUND
HEALTHCARE COOPERATIVE

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

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 OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following people or company(ies) have the right 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

❍ **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 and banking). 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 one (1) year from the date of my signature below. 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 the use and 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 CGHC does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

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 representative on behalf of the patient, complete the following:

Representative's Name: _____ Relationship to Member: _____

COMMON GROUND
HEALTHCARE COOPERATIVE

NON-DISCRIMINATION NOTICE AND AVAILABILITY OF LANGUAGE LINE ASSISTANCE SERVICE

Common Ground Healthcare Cooperative (CGHC) complies with applicable Federal civil rights laws and does not discriminate. This means that we do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CGHC provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, etc.) We also provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services please call us at 877.514.2442.

If you feel that CGHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax or email by contacting:

Civil Rights Coordinator:	Judy Zarnowski
Phone Number:	414.269.4684 (TTY: 844.472.2442)
Fax Number:	262.754.9690
Email:	CivilRights@CommonGroundHealthcare.org
Mail:	120 Bishop's Way, Suite 150 Brookfield, WI 53005-6271.

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 to U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building Washington, DC 20201 or by phone at 1.800.368.1019 or 1.800.537.7697(TDD). 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** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.514.2442 (TTY/TDD: 711)
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: ถ้ ุ คุณพดภาษาไทยคุณสามารถใชบ้ ริการชว่ ยเหลอื ทางภาษาได ฟ้ ร โทร 1.877.514.2442 (TTY/TDD: 711).	**Laotian** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.877.514.2442 (TTY/TDD: 711)
Hindi ध्यान द : य द आप हिंदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध 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)