



HEALTHCARE COOPERATIVE

CGHC Claims and Correspondence
120 Bishop's Way, Suite 150
Brookfield, WI 53005
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, Identification Number, Group Number

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, My Domestic Partner, My Adult Child(ren), My Parents, My Insurance Broker/Agent, Other

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

Transferring or Continued Medical Care, Personal Use, Insurance Eligibility/Benefit, Disability Determination, Legal Investigation, Upcoming Appointment Date, Other

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, Procedures, Immunization Records, Lab Reports, X-ray Reports, X-ray Films, Billing Records, Specific information related to, For the following date(s) or timeframe

*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:



Common Ground Healthcare Cooperative (CGHC) is required by law to include the following information with any significant document we provide you:

Notice of Nondiscrimination and Availability of Language Assistance Services

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, other formats)
- 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 call 877-514-2442.

If you believe 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 by contacting:

Civil Rights Coordinator:	Wayne Creggett
Telephone Number:	414-269-4684
TTY:	844-472-2442
Mailing Address:	120 Bishop's Way, Suite 150 Brookfield, WI 53005-6271
Fax Number:	262-754-9690
Email Address:	civilrights@commongroundhealthcare.org

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance, Wayne Creggett, 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 for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Foreign Language Assistance

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-514-2442.

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.

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。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 1-877-514-2442.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
1-877-514-2442

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-514-2442.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-514-2442 번으로 전화해 주십시오.

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.

Pennsylvania Dutch

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-514-2442.

Laotian

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ້ນຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-514-2442..

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-514-2442.

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-514-2442.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-514-2442. पर कॉल करें।

Albanian

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-514-2442.

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.