Wellmark®

AUTHORIZATION

This form is used to authorize Wellmark to disclose protected health information at the request of the individual.

INDIVIDUAL AUTHORIZING DISCLOSURE

Name:_____

Address:_____

City, State, ZIP Code:_____

Telephone:_____ Email:_____

Identification Number:_____ Social Security Number:_____

USE OR DISCLOSURE BEING AUTHORIZED

Entity Authorized to Disclose: Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., Wellmark Synergy Health, Inc., Wellmark Value Health Plan, Inc., or Wellmark Blue Cross and Blue Shield of South Dakota (collectively "Wellmark").

Protected Health Information to be Disclosed: Specifically and meaningfully describe the protected health information you are authorizing to be disclosed:

_____

_____

Persons or Entities Authorized to Receive: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing the disclosure and subsequent use of the protected health information described above:

_____

_____

Effect of Granting this Authorization: I understand that if the person or entity that receives the information requested is not covered by federal or state privacy laws, the information described above my be redisclosed and will no longer be protected by law.

Prohibition on Redisclosure: This form does not authorize the disclosure of medical information beyond the limit of the authorization. Where information has been disclosed from the records protected by Federal law for alcohol/drug abuse records or state law for mental health records, the Federal requirements (42 CFR Part 2) and state requirements (Iowa Code Chapter 228 or South Dakota Codified Laws Chapter 27A-12) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient or this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

No Conditions: This authorization is voluntary. Wellmark will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

EXPIRATION AND REVOCATION

Expiration: This authorization will expire upon termination of my health plan coverage, or upon settlement of claims incurred while covered, unless revoked or an earlier date or event is entered below.

☐ On_____/_____/_____ (Date)

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

_____

_____

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Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Wellmark at the address stated below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation and, if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

INDIVIDUAL'S SIGNATURE

Specific Authorization for Release of Mental Health, Substance Abuse Treatment or AIDS-Related Information: I authorize and consent to the release and disclosure of any and all personal health information, including specifically mental health information, substance abuse (drug or alcohol), and AIDS-related information, if applicable, and all claims information to the individual or entity named above as long as this authorization is in effect. I understand that I may inspect the mental health information disclosed.

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

Signature: _____ **Date:** _____/_____/_____

A *spouse or parent of an individual 18 years or older may NOT sign on behalf of the individual without appointment through a legal process or by the individual submitting a personal representative appointment form.*

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

RETAIN A COPY FOR YOUR RECORDS

SOUTH DAKOTA MEMBERS send completed and signed form to:

Wellmark Blue Cross and Blue Shield
Customer Service, Mail Station 347
PO Box 5023
Sioux Falls, SD 57117-5023

Or fax to (515) 376-9098

ALL OTHER MEMBERS send completed and signed form to:

Wellmark Blue Cross and Blue Shield
Privacy Office, Mail Station 5W590
PO Box 9232
Des Moines, IA 50306-9232

Or fax to (515) 376-9032

INSTRUCTIONS:

1. "INDIVIDUAL AUTHORIZING DISCLOSURE" - this is information about you. We need to have your name, address, phone number, email address (if you have email), identification number and social security number in this section.

2. "Protected Health Information to be Disclosed" - you must tell us what information you are authorizing us to release. (i.e., claim status, claim payment, premium amounts, etc.)

3. "Persons or Entities Authorized to Receive" - this is where you tell us to whom we may release your protected health information.

4. "EXPIRATION AND REVOCATION" - if you do not fill out this section, the authorization will continue until you no longer have health insurance coverage with Wellmark. However, you may specify a **date** for the authorization to terminate or an **event** upon which the authorization will terminate. An example of an "event" would be "When claims for denied services have been resolved."

5. "INDIVIDUAL'S SIGNATURE" - we must have your signature or the signature of your legal guardian. If your legal guardian signs this section, we will have to have a copy of the court document appointing the guardianship. If the information being released is for someone under the age of 18, a parent (or legal guardian) signs, please complete the last 2 lines of the form with the name and relationship to the member.

Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်နှးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙላው ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heƃir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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