



Aspirus Health Plan ID #: \_\_\_\_\_

**RELEASE OF INFORMATION FORM**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Aspirus Health Plan or (specify) \_\_\_\_\_  
may release to:

*Name of person or entity to have the following information:*

<input type="checkbox"/> My name	<input type="checkbox"/> HIV / Aids	<input type="checkbox"/> Assessments	<input type="checkbox"/> Restriction
<input type="checkbox"/> Claims	<input type="checkbox"/> Alcohol / drug use	<input type="checkbox"/> Authorization	<input type="checkbox"/> information
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> treatment	<input type="checkbox"/> Appeals and	<input type="checkbox"/> Photograph of me
<input type="checkbox"/> Enrollment	<input type="checkbox"/> Mental health	<input type="checkbox"/> complaints	<input type="checkbox"/> Financial
<input type="checkbox"/> Disease	<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Customer Service	<input type="checkbox"/> Demographic
<input type="checkbox"/> Management plans	<input type="checkbox"/> Utilization review	<input type="checkbox"/> Provider records	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Care plans			

- All records and information as checked above.
- Records for only some date(s) or time period: \_\_\_\_\_

The reason for this release is:

<input type="checkbox"/> Member's request	<input type="checkbox"/> Research	<input type="checkbox"/> To explain Aspirus	<input type="checkbox"/> Media release
<input type="checkbox"/> Continuity of care	<input type="checkbox"/> Appeal/complaint	<input type="checkbox"/> Health Plan's	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Disease		<input type="checkbox"/> programs and	
<input type="checkbox"/> Management		<input type="checkbox"/> services	

This release will last until: \_\_\_\_\_  
(Specify date, event or condition)

By signing this form:

- I agree that Aspirus Health Plan may use and release information about me for the reasons checked above.
- I have the right to cancel this release in writing at any time.
- I understand and agree that even if I cancel this release, information might have already been shared before I canceled the release.
- Any information used or disclosed may no longer be protected by law. It may also be subject to re-disclosure by the person or organization receiving it.
- I understand that I do not have to sign this release.
- If I do not sign this release, it will not affect my health coverage.
- I understand that the information released may let others know that I am a person on a Wisconsin health care program.
- I understand and agree to the terms in this release form.
- I hereby release Aspirus Health Plan from any and all claims arising out of or in connection with the use of the released information.

\_\_\_\_\_  
*Signature of Individual authorizing release*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of witness (if required)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of parent, guardian or authorized representative (if required)*

\_\_\_\_\_  
*Date*

Return form to:  
Aspirus Health Plan  
PO Box 51  
Minneapolis, MN 55440  
Fax 715-787-7307  
Email [CLSScanReqIncMA@aspirushealthplan.com](mailto:CLSScanReqIncMA@aspirushealthplan.com)

## **Notice of Nondiscrimination**

Aspirus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **715-631-7411 (voice)** or toll free at **1-855-931-4850 (voice)**, **715-631-7413 (TTY)**, or **1-855-931-4852 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**.

If you believe that Aspirus Health Plan 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 an oral or written grievance.

### Oral grievance

If you are a current Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

### Written grievance

#### *Mailing Address*

Attn: Appeals and Grievances

Aspirus Health Plan

P.O. Box 51

Minneapolis, MN 55440

Email: [cagMA@aspirushealthplan.com](mailto:cagMA@aspirushealthplan.com)

Fax: 715-631-7439

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, 1-800-537-7697 (TDD)

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

