WELS VEBA GROUP HEALTH PLAN

Consent for Release of Personal & Health Information

Member Information: (Individual whose information will be released)

Name: _____ Date of Birth:_____

Address: _____ Zip: _____

Telephone Number: (Including area code) _____

Group Plan #: _____ Member ID#: _____

I authorize the use or disclosure of personal and health information by WELS VEBA Group Health Plan as described below:

- ‘ Any and all personal and health information WELS VEBA Group Health Plan maintains.
- ‘ Personal and health information regarding the treatment for the following condition or injury: _____on or about _____
- ‘ Personal and health information covering the period of time _____to _____
- ‘ Other (Please specify and include dates:)_____

_____

This information may be disclosed to, and used by, the following individuals or organizations:

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____Zip Code: _____

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____Zip Code: _____

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____Zip Code: _____
Purpose of Disclosure:_____

_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to the WELS VEBA Benefit Plans Office. Unless otherwise revoked, this authorization will expire in 365 days.

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of Member: _____ **Date:** _____