



**AUTHORIZATION FOR DISCLOSURE TO HOUSING AUTHORITY**

This form is used to authorize Wellmark to disclose premium information to a housing authority at the request of the individual.

**INDIVIDUAL AUTHORIZING DISCLOSURE**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**USE OR DISCLOSURE BEING AUTHORIZED**

**Entity Authorized to Disclose:** Wellmark Blue Cross and Blue Shield or Wellmark Health Plan of Iowa, Inc.

**Protected Health Information to be Disclosed:** Amount of premium for health insurance.

**Name of Housing Authority Authorized to Receive:** \_\_\_\_\_

**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 may 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 limits 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 (SDCL 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 for 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 30 days after 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):

\_\_\_\_\_  
\_\_\_\_\_

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to Wellmark Blue Cross and Blue Shield 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 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 – Send completed and signed form to:**

Wellmark Blue Cross and Blue Shield  
1601 W. Madison  
Sioux Falls, SD 57104

If you have questions about how to complete this form, please call (877) 610-6395.