Authorization of Disclosure of Protected Health Information
(Form to Use When Someone Call DirectPath About Another Person)

DirectPath
To Reduce Health Care Costs

This form is used for you, as a recipient of DirectPath advocacy services through your employer, to authorize another individual to receive and access the member's protected health information which is obtained by DirectPath to resolve a specific health care issue on behalf of the member. Information to be disclosed will be directly related to the issue to be resolved and may include complete health record(s), photographs, videotapes, x-rays, digital or other images, and genetic health information. This information may also include information relating to AIDS or HIV, psychiatric care, treatment for alcohol and/or drug abuse, and genetics.

You may restrict the information to be disclosed by indicating below the protected health information that you want handled in a restricted manner and the restriction you want applied:

SECTION A: PATIENT INFORMATION

EMPLOYER		ADDRESS			
NAME		CITY			
DATE OF BIRTH		STATE		ZIP	
INSURANCE ID#		PHONE#			
SSN#		EMAIL			

SECTION B: AUTHORIZED RECIPIENT(S) (Person or Entity who will receive your information)

NAME		SSN#			
ADDRESS		RELATIONSHIP			
CITY					
STATE		ZIP			

Authorized dates of service: ☐ All dates of services **Date Range:** From _____ To _____

Expiration: This authorization will automatically expire when you are no longer eligible to receive DirectPath advocacy services though your employer.

Right to Revoke: You may revoke this authorization at any time, except to the extent that action or release has been taken in reliance on this authorization by fiving written notice to the address listed at the bottom of this page.

I understand that by signing this document, I am authorizing DirectPath to use and/or disclose protected health information to the individuals noted herein for the purpose of providing DirectPath advocacy services for me. When the information is used or disclosed pursuant to the authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

SIGNATURE: _____ **Date:** _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following and attach legal documentation of Legal Guardian or Holder of Power of Attorney:

Personal Representative's Name:	
Relationship to Patient:	

If this authorization is signed by a personal representative on behalf of the individual, complete the following and attach legal documentation of Legal Guardian or Holder of Power of Attorney:

Please retain a copy for your records, and a copy can be provided to you by DirectPath upon request.

Please complete and return this form to:

DirectPath Privacy Office
633 W. Wisconsin Ave Suite 1310
Milwaukee, WI 53203
Fax: (414) 301-6963