



# Consent Form

WPS Health Plan, Inc.  
P.O. Box 11625  
Green Bay, WI 54307-1625  
Fax: 920-490-6928  
Phone: 920-490-6979

**This form is used to obtain an individual's consent to allow a representative(s) of their choice to access the individual's protected health information for 30 months.**

**SECTION A: Individual Giving Consent.**

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

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

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Subscriber Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B: Consent - Please read the following statements carefully.**

The following are representatives to whom I agree to permit WPS Health Plan, Inc. to disclose my protected health information. The nature of the disclosures include but are not limited to payment issues, benefit determination, and coverage of services - unless restrictions are noted in Section C. I understand that WPS Health Plan, Inc. is not obligated to determine the legitimacy of a disclosure request made by a representative to whom I have granted consent.

Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

**SECTION C: Restrictions on Consent.**

You have the right to request that WPS Health Plan, Inc. restrict the nature of the disclosures made to the representatives you identified in Section B. Please indicate below any restrictions you want on these disclosures.

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

**SECTION D: Right to Revoke.**

You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will *not* affect any action we took in reliance on this consent before we received your written notice of revocation.

**SECTION E: Signature.**

I have had full opportunity to read and consider the contents of this form. I understand that, by signing this form, I am giving my consent for WPS Health Plan, Inc. to disclose my protected health information to the representatives identified above.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_