

**DEAN HEALTH PLAN, INC. AND DEAN HEALTH INSURANCE, INC.**  
**(“DEAN”)**

**AUTHORIZATION FORM**

**To Permit Use and Disclosure of Protected Health Information**

**PURPOSE OF THIS FORM:** You should use this Authorization Form when you wish to give another person access to your health information. When completed, it will allow DEAN to disclose your health information to the person(s) stated on this form.

**SECTION A: Individual Authorizing Use and/or Disclosure**

Name of Member	Subscriber Number	Date of Birth
Street Address	Telephone	
City, State, Zip Code		

**SECTION B: The Use and or Disclosures Being Authorized**

**I hereby authorize the following disclosure of my protected health information as indicated below by DEAN, 1277 Deming Way, Madison, WI 53717.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Case Management Records | <input type="checkbox"/> Claims Correspondence | <input type="checkbox"/> Claims Payment Summary |
| <input type="checkbox"/> Enrollment Records      | <input type="checkbox"/> Other (Specify) _____ |   |

**For the following date(s)** \_\_\_\_\_

**Specific purpose of the use or disclosure: (check applicable categories)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Assist me with all matters involving my eligibility for coverage or claims for benefits under my DEAN health benefit plan.                      |   |  |
| <input type="checkbox"/> Assist me with certain matters (describe) involving my eligibility for coverage or claims for benefits under my DEAN health benefit plan. _____ |   |  |
| <input type="checkbox"/> Coordination of benefits  | <input type="checkbox"/> Payment of claim(s)            | <input type="checkbox"/> Prior authorization |
| <input type="checkbox"/> Grievance   | <input type="checkbox"/> Insurance eligibility/benefits | <input type="checkbox"/> Personal Reasons    |

**To disclose protected health information to:**

Name of Individual/Organization
Relationship to Me
Street Address
City, State, Zip Code

**SECTION C: Individual's Signature**

**Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form and that DEAN may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

**Right to Withdraw This Authorization** - I understand written notification is necessary to revoke this authorization. To obtain information on how to revoke my authorization, I may contact Customer Services at (800) 279-1301. I am aware that my revocation will not be effective until received by DEAN and that it will not have any effect on disclosures made prior to receipt of my revocation.

**Re-disclosure Notice** - I understand once that DEAN discloses my information based on this authorization, this information may no longer be protected by federal and state privacy standards and that my health information may be re-disclosed without obtaining my authorization.

**Expiration** - This authorization will expire 36 months from the date signed, unless I specify another date or event here: \_\_\_\_\_

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization form, I am confirming that it accurately reflects my wishes. I am entitled to keep a copy of this form for my records.

Signature of You or Your Personal Representative: \_\_\_\_\_

Please Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**If signed by a Personal Representative, please attach appropriate documentation verifying legal authority, such as Guardianship or Power of Attorney Documents.**