BPA Benefit Plan Administrators
402 Graham Avenue • PO Box 1128 • Eau Claire, WI 54702-1128 PHONE: (800)236-7789 • (715)832-5535 • FAX: (715)838-8507

HIPAA COMPLIANT CONSENT TO PROVIDE INFORMATION

Patient Information:

Name of Patient _____ Birthdate _____ SS# _____

Information to be released from: Benefit Plan Administrators (BPA)

Information to be provided to:

☐ Privacy Officer of Group Health Plan

☐ The following named Individual(s):

_____
Name of Designated Recipient

_____
Address

_____
City, State, Zip Code **Telephone**

_____
Name of Designated Recipient

_____
Address

_____
City, State, Zip Code **Telephone**

Information to be released:

☐ General claim payment information.

Information NOT to be released:

☐ Specific information (please be specific): _____

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

To exclude the following information from the information provided, please initial:

_____ Drug/ Alcohol abuse/treatment & diagnosis _____ Sexually Transmitted Disease

_____ HIV/AIDS diagnosis/treatment/testing _____ Mental Illness or Psychiatric

My Rights:

I understand that once the health information I have authorized be provided to the noted recipient, that person may re-disclose it, at which time it may no longer be protected under Privacy laws. A copy of the authorization is as valid as the original. The authorization will remain valid from the date of my signature until such time as I revoke this authorization in writing.

Important - Regarding BPA e-Services (website): BPA will allow viewing of information regarding your spouse/adult dependents if authorized. However, I understand I must first register/login at least one time on BPA's Member website in order for BPA to update the website with the requested release of information. (Changes requested in this consent form.)

SIGNATURE: _____ **DATE:** _____
Patient Signature/Patient Representative

_____ _____
Witness Signature (Required) **Relationship**