# CONSENT FORM

**Arise Health Plan**
**P.O. Box 11625**
**Green Bay, WI 54307-1625**
**920-617-6330**
**Toll-free 1-888-711-1444 ext. 8330**
**Fax: 920-490-6928**
**BillingandEnrollment@wpsic.com**

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 includes but is 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 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 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 disclosure my protected health information to the representatives identified above.

Printed Name: ______________________________ Date: ____________________

Signature: ______________________________