RELEASE OF INFORMATION AUTHORIZATION

Submit this completed form via one of the following methods:	Online Support Request	Fax	Mail
	Log onto your online account at https://cda.basiconline.com/ and attach the completed form via Support Request	(269) 327-0716	BASIC PO Box 6278 Monona, WI 53716

I hereby authorize the use or disclosure of my individually identifiable health information as described below.
I understand that this authorization is voluntary, that I may refuse to sign this authorization and that I may revoke it at any time by submitting my revocation in writing to BASIC.

EMPLOYER INFORMATION

Client/Employer Name:		**Client/Employer ID #:** (If known)	
Division: (If applicable)			

INDIVIDUAL/PARTICIPANT INFORMATION

First Name:		**MI:**		**Last Name:**	
Benefits ID: (12 digit)		**Email Address:**			
Primary Phone #:		**Mobile Phone #:**			
Primary Address:	**Address Line 1:**			**Apt:**	
	Address Line 2:				
	City:				
	State:		**ZIP/Postal Code:**	**+4**	

All fields required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.

AUTHORIZATION

Authorized Representative (Persons/Organizations): _____
(Print Name)

Above named representative(s) is authorized to receive information for the purpose of:

☐ Serving as my personal representative on appeals for all of my BASIC Accounts. If this representative is only for a specific account(s), please indicate the specific account(s):

☐ Other *(describe)*:

All of my health information may be disclosed: ☐ **Yes** ☐ **No** *(If no, please describe below)*

Specific information to be used or disclosed:

AUTHORIZATION SIGNATURE(S) REQUIRED ON PAGE 2

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☐ **I understand the specific purpose of the disclosure may be made at the request of the authorized representative (with a current authorization on file).**

☐ **I understand this authorization will expire upon termination of coverage. However, I may revoke authorization at any time by submitting written revocation to BASIC.**

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying BASIC, in writing, but the revocation will not have any effect on any actions that the authorized representative took before receiving the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving authorized representative. I have the right to seek assurances from the above-named authorized representative that they will not re-disclose the information to any other party without my further authorization.

Signature of Participant: _____ Date: _____
(or Authorized Representative, if previously authorized)

Participant Name (Printed): _____