DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-13154 (08/2020)

STATE OF WISCONSIN
P.L. 104-191

WISCONSIN CHRONIC DISEASE PROGRAM (WCDP)

HIPAA PRIVACY ACCESS REQUEST

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require DHS, as a covered entity, to implement processes that give patients certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Provision of the information that is requested on this form is voluntary. Although the use of this version of the form is voluntary, all of the information outlined on this form is mandatory.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

INSTRUCTIONS: Mail this completed form to the following address:

WCDP
Member Services
PO Box 6410
Madison WI 53716

SECTION I – MEMBER INFORMATION

Name – Last, First, Middle Initial	WCDP Identification Number
Address – Street, City, State, ZIP Code	Phone Number ( )

☐ Check this box if you want your health information records mailed to a different address. If so, complete the information below.

Address – Street, City, State, ZIP Code

SECTION II – ACCESS POLICY SUMMARY AND REQUEST

You have the right to see or copy enrollment, claim, or other records used to make decisions about your health plan services by the Wisconsin Chronic Disease Program (WCDP). WCDP will not include information prepared for legal actions or proceedings, criminal investigations or prosecutions, notes made by a mental health therapist or psychiatrist, and certain other records. Complete this form to request access to enrollment, claim, or other records used to make decisions about your health plan services by the WCDP.

Specify the records to be inspected or copied:

☐ enrollment
☐ claim
☐ other (please specify)

Specify the specific timeframe of the records to be inspected or copied:

☐ 1 month _____
☐ 3 months _____
☐ 6 months _____
☐ other _____

☐ I want a copy of these records
☐ I want to inspect these records

You may be charged a fee for the costs of copying, mailing, or for other supplies needed to fulfill your request. You will be notified of any costs prior to receiving the requested copies.

If you want us to provide copies of your records to any person other than you or your personal representative, you must provide us with a signed authorization. We can supply you with the appropriate authorization form.

SECTION III – SIGNATURES

Please sign the form and complete the appropriate information

SIGNATURE – Member	Date Signed

If this request is from a personal representative on behalf of the member, provide a copy of the documentation to support the representation and complete the following:

Name – Personal Representative	Relationship to Member
SIGNATURE – Personal Representative	Date Signed

RESET FORM