Health & Wellness Services

Winona State University

AUTHORIZATION FORM

1. **I authorize WSU Health & Wellness Services (H&WS), its employees or agents, to release Medical Information** for the following:**
   - Necessary for processing insurance claims to all insurers, their agents or review organizations; and/or the Centers of Medicare and Medicaid Services (CMS) or its agents.
   - To contact my insurance company or health plan administrator, their agents or review agencies, or other third party payer to obtain all pertinent financial information concerning coverage and payments made under my policy. I direct the insurance company or health plan administrator, their agents or review agencies, or other third party payer to release such information to WSU Health & Wellness Service.
   - To billing Addressee as part of handling the billing, payment, and insurance coverage for my account to the person(s) I have designated as my Billing Addressee.

2. **Authorization to Assign Benefits**
   I authorize and request my insurer to pay directly to the H&WS any benefits due under the terms of this policy for services and medications provided by the . I understand that the H&WS reserves the right to refuse such assignments of medical benefits. If my health insurance will not allow direct payment to H&WS or if they choose not to accept assignment of medical benefits, I agree to immediately forward to WSU H&WS all health insurance payments I receive.

3. **Authorization to Release Medical Information** to Other Health Care Providers** (including WSU Counseling Department and WSU Athletic Training Staff and Winona Health).
   I further authorize the H&WS, its employees or agents, to release medical information** to my other health care providers for continuing care purposes.

4. **Payment Authorization: Statement of Financial Responsibility**
   I acknowledge I am responsible for all charges for services and medications provided to me including any amount not paid by my insurance plan(s), government program benefits, or other third-party payers and these will be applied to my WSU student account. I am also aware that failure to show up for a scheduled appointment, without notification, will result in an added fee to my account.

5. **Statement of Receipt of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices:** I acknowledge that I have been made aware of and can receive a copy of the HIPAA Notice of Privacy Practices.

6. **Electronic Communication:** I agree to allow H&WS to use electronic communication. This communication will not include details about my personal health records.

These authorizations are valid until revoked by me at any time by notifying WSU Health & Wellness Services in writing, except to the extent that WSU Health & Wellness Services has already taken action in reliance upon it. This form supersedes all prior versions of this form signed by me.

Signature required: _____ Date: _____ /_____ /_____
(Patient's signature; legal guardian if under 18 year of age)

Printed Name: _____ Date of Birth ____ / ____ / ____

Warrior ID: _____ Preferred Email Address: _____

Rev: 01/28/2020