P.O. Box 5533
Marion, IL 62959

WPS AUTHORIZATION To Permit Use and Disclosure of Health Information

Beneficiary Name: ____________________ Medicare Number: ______________

I hereby authorize the following use or disclosure of my individually identifiable health information:

Specific *description* of the information to be used or disclosed: ____________________

Specific *purpose* of the use or disclosure: LEGAL REVIEW

Person/organization authorized to *provide* the information: **WPS Medicare Part B (Freedom of Information Act) FOIA Officer**

Person/organization authorized to *receive* the information: MINUTE MAN SERVICES, INC
3318 N MAIN ST ROYAL OAK, MI 48073

I understand that I have the right to revoke this authorization at any time. I must do so by writing to the same person(s) or class of persons that I directed this authorized to. The revocation will not apply to information that has already been released in response to this authorization.

I understand that my refusal to authorized disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for health services I receive.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by law.

This authorization will expire in 30 months from the date signed or on ____________.
(Indicate a date or event that relates to you, the Customer, or the purpose of the authorization.)

Signature of Beneficiary or Beneficiary's Personal Representative:	
Please print name:	**Date:**
If signed by Beneficiary's Personal Representative, describe Representative's authority to act on behalf of the Beneficiary and attach documentation showing this authorization.	