

## Authorization for Release of Health Information

\_\_\_\_\_  
Member's Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Member or Subscriber ID #

\_\_\_\_\_  
Member's Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

### I understand and agree that:

- this authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

### Who May Receive and Disclose my Information:

I authorize UnitedHealthcare and its affiliates to receive from or disclose my individually identifiable health information to the following person(s) or organization(s):

\_\_\_\_\_  
(Full Name of Person(s) or Organization(s))

\_\_\_\_\_  
(Full Address &/or Phone number of Person(s) or Organization(s))

### Type of Information to be Disclosed:

- I authorize disclosure of all my health information including information relating to claims, medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; **or**
- I authorize only the disclosure of the following information:

\_\_\_\_\_  
(Type of Information)

**Purpose of Disclosure:**

- My health information is being disclosed at my request or at the request of my personal representative; **or**
- My health information is being disclosed for the following purpose:

\_\_\_\_\_  
(Explain Purpose)

\*\*\*\*\*

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature *(For Illinois Residents Only)*

\_\_\_\_\_  
Date

**Please note:** If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

\_\_\_\_\_  
Signature of Member's Representative

\_\_\_\_\_  
Date

Personal Representative's:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

*(For California and Georgia residents only)* I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

**PLEASE MAINTAIN A COPY OF THIS FORM FOR YOUR RECORDS AND RETURN IT TO:**

**Fax: 866-322-0051**

**or**

**Mail:** ATTN Optum ROI Processing

11000 Optum Circle |

Mail Route: MN103-0600

Eden Prairie, MN 55344