Authorization for Release of Health Information

Follow these instructions to complete the form.

Member's personal information

Write your full name, date of birth, address and member/subscriber ID in this section.

Who may get and share my information

Write the full name and address of the person(s) or organization(s) you are allowing to get information from or share information with.

Type of information to be shared

Check one of the boxes. If you check the second box, write what information we may share.

Purpose of disclosure

Check one of the boxes. If you check the second box, write the purpose of the release of information.

Signature

To be valid, the form must be signed and dated. Illinois members also need the signature of a witness.

Personal representative

If you have a guardian or court appointed representative, they must complete this section. They will also need to attach a copy of their legal proof of authority.

Authorization for Release of Health Information

Please keep a copy of this form for your records.

Member's personal information

Full name _____

Address _____

City _____ State _____ ZIP _____

Member/Subscriber ID _____ Date of birth _____

I understand and agree that:

- This authorization is voluntary.
- My health information may be from third parties. This may include health care providers. It may be these types of information:
    - o Medical records
    - o Pharmacy
    - o Dental records
    - o Vision care
    - o Mental health
    - o Substance abuse care
    - o HIV/AIDS
    - o Psychotherapy
    - o Reproductive care
    - o Communicable disease
- I may not be denied treatment or payment for health care if I don't sign this form. I may not be denied eligibility for health care if I don't sign this form.
- My health information may be shared by the recipient. If the recipient is not a health plan or provider, the information may not be protected by the federal rules.
- This permission will expire 1 year from the date I sign it. I may cancel it at any time. To do so, I must tell UnitedHealthcare in writing. The revocation will not have an effect on any actions prior to the date it is processed.

Who may get and share my information

I give permission for UnitedHealthcare and its affiliates to get from or share my health information with:

_____

Full name of person(s) or organization(s)

_____

Full name of person(s) or organization(s)

Type of information to be shared

Check one of the boxes.

- ☐ I authorize disclosure of all my health information. This includes these types of information:
    - Medical records
    - Substance abuse care

- Pharmacy
- Dental records
- Vision care
- Mental health
- HIV/AIDS
- Psychotherapy
- Reproductive care
- Communicable disease

☐ I authorize only the disclosure of the following information:

_____

Purpose of disclosure

Check one of the boxes.

☐ My health information is being shared at my request or at the request of my representative.

☐ My health information is being shared for this purpose:

_____

Signature

_____ _____

Signature of member Date

_____ _____

Witness signature (*For residents of Illinois only*) Date

Personal representative

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

Personal representative's name _____

Address _____

City _____ State _____ ZIP _____

Phone number _____

_____ _____

Signature of member's representative Date

Ready to send the completed form?

Send the signed and completed form to:

UnitedHealthcare Community and State
PO Box 30753
Salt Lake City, UT 84130

Fax: 1-844-386-9286

Please keep a copy of this form for your records.

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