Revocation of Authorization for Release of Health Information

Use this form to revoke or take away permission to get or share health information.

Member's Personal Information

Full Name _____

Address _____

City _____ State _____ ZIP _____

Date of Birth _____

Member or Subscriber ID Number _____

Who is being revoked from getting and sharing my information?

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

_____

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

_____

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

Signature

By signing below, I understand and agree that:

- This revocation is voluntary.
- I may not be denied treatment or payment for health care if I do not sign this form. I may not be denied eligibility for health care if I do not sign this form.
- Cancellation of my permission is effective on the date my request is processed.

_____ _____

Signature of Member or Member's Representative Date

_____ _____

Witness Signature *(For residents of Illinois only.)* Date

Note: If you are a guardian or court appointed representative, please complete the section on the back of this page. You must also attach a copy of your legal authorization to represent the member.

Guardian or Court Appointed Representative Information

Full Name _____

Address _____

City _____ State _____ ZIP _____

Phone Number _____

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.