Authorization for Release of Health Information

Please keep a copy of this form for your records.

Member's personal information

Full Name _____

Member/Subscriber ID _____ Date of Birth _____

Address _____

City _____ State _____ ZIP Code _____

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 do not sign this form. I may not be denied eligibility for health care if I do not 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 one year from the date I sign it. I may revoke it at any time. To do so, I must notify 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
- Pharmacy
- Dental records
- Vision care
- Mental health
- Substance abuse care
- 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 Code _____

Phone Number _____

_____ _____

Signature of Member's Representative Date

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