UnitedHealthcare®
A UnitedHealth Group Company

Authorization for Release of Information

Member's Name	Date of Birth	☐ Member or Subscriber ID#	☐ Chart #

Member's Street Address	City	State	Zip Code

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying UnitedHealthcare in writing. However, the revocation will not have an effect on any actions UnitedHealthcare took before it received the revocation.

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

Name: _____

Address: _____

City	**State**	**Zip**

Phone Number: (___) _____ Extension _____

Description of individually identifiable health information to be received or disclosed (check appropriate type(s) of information):

☐ All
☐ Claims
☐ Eligibility/Benefits
☐ Information used to make benefit determinations
☐ Treatment Plan(s)
☐ Progress Reports
☐ Attendance Only
☐ All pertinent information UnitedHealthcare deems appropriate for the purpose checked below
☐ Other (describe): _____

The purpose of this authorization is (check all that apply):

☐ To allow the appropriate management of treatment, services, and/or coverage under the member's benefit plan.
☐ Benefit Management
☐ Claims Administration/Payment
☐ Employer Mandated Treatment Referral
☐ Administration of a Worker's Compensation claim
☐ Administration of a Disability claim
☐ Subpoena or other legal process
☐ Other (describe): _____

The dates of records to be disclosed:

From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

THE MEMBER OR MEMBER'S REPRESENTATIVE MUST COMPLETE THE REST OF THIS FORM:

I understand that this authorization will expire:

☐ On _____ (MM/DD/YYYY) or one year from the date of the signature below (or as set forth in the applicable state-specific provisions below).

OR

☐ Once the following event occurs **(*does not apply to Illinois residents*)**:
_____

(Form must be completed before signing)

Signature of Member/Legal Guardian or Member's Representative	Signature of Minor Member	Date
Print Name of Member/Legal Guardian or Member's Representative	Relationship to Member	Description of Representative's Authority