UMR
A UnitedHealthcare Company

Authorization for Release of Health Information

Member's name/Person granting access _____

Date of birth ____/____/____ (MM DD YY) Member or subscriber ID# _____

Member's street address _____ City _____ ST ____ Zip _____

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 of person(s) or organization(s) _____

Type of information to be disclosed *(select one option):*

○ I authorize disclosure of all my health information including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.

○ I authorize only the disclosure of the following information:

Type of information _____

Purpose of disclosure *(select one answer):*

○ My health information is being disclosed at my request or at the request of my personal representative.

○ My health information is being disclosed for the following purposes:

Explain purpose _____

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Signature of member *(required)* _____ Date ____/____/____
MM DD YY

Witness signature *(For Illinois residents only)* _____ Date ____/____/____
MM DD YY

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 ____/____/____
MM DD YY

Print name _____ Phone number ____-____-____

Street address _____ City _____ ST ____ Zip _____

(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 DOCUMENT FOR YOUR RECORDS

Please return the completed form to:

UMR, PO Box 30541, Salt Lake City UT 84130-0541 ***OR*** Fax: **888-742-4179**