Authorization for Release of Information

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

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 OptumHealth in writing. However, the revocation will not have an effect on any actions OptumHealth took before it received the revocation.

I authorize OptumHealth and its affiliates 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 relevant information related to my healthcare services
- ☐ Claims
- ☐ Eligibility/Benefits
- ☐ Information used to make benefit determinations
- ☐ Health Care Programs – Care Solutions, Behavioral Health, Disease Management
- ☐ Treatment Plan(s)
- ☐ Progress Reports
- ☐ EAP Participation

☐ 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
☐ Other (describe): _____
☐ Administration of a Worker's Compensation claim
☐ Administration of a Disability claim
☐ Subpoena or other legal process

All dates of records will be disclosed unless you indicate differently below.

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*)**:
_____

_____ _____
Signature of Individual Date

Please note: If you are a guardian or court appointed representative for the individual, you must attach copies of your authorization to represent the individual in order to obtain access to his/her Protected Health Information.

_____ _____
Signature of Individual's Representative Date

Personal Representative's Name_____

Address_____

City_____ State _____Zip _____Phone (_____) -_____

Relationship to individual and authority to act for individual:

_____

_____ _____
(For Illinois residents only) Witness Signature Date of Witness Signature

(*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.

(*For California and Georgia residents only*) A copy of this form has been requested and received:
_____ Yes _____ No

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

PLEASE NOTE THE FOLLOWING STATE-SPECIFIC PROVISIONS:

Arizona: The request must be in writing and signed by the person requesting the medical records. The person requesting the medical records must demonstrate the authority to have access to the records.

California: The patient or the person signing this form has the right to receive a copy of the form.

Georgia: Advises that the individual, or the individual's authorized representative, is entitled to receive a copy of the authorization form.

Illinois: A witness signature is required. The authorization must specify expiration date as a calendar date (i.e., month/day/year). If no calendar date is specified, the information may be released only on the day the consent form is received. Must include right to inspect and copy information to be disclosed. Must also include consequences of refusal to consent, if any. Records do not include information regarding HIV/AIDS status without an authorization that explicitly and specifically includes the release of such information.

Indiana: Expiration of the authorization may be a date, event or other condition. If no expiration is specified, the authorization is valid for 180 days after the date the request was made.

Iowa: The individual has the right to inspect the disclosed information at any time.

Minnesota: Authorization expires on the earlier of the specific date stated or one year from date signed.

Oregon: Unless revoked earlier, the authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

Virginia: To be valid, the authorization must state the inclusive dates of the records to be disclosed.

Washington: Authorization expires on the earlier of the specific date stated or 90 days after signed, including authorization to release future health care information, except information to third party health care payors.