HIPAA Authorization for the Use and Disclosure of Health Information

By completing and signing this form, I, or my personal representative, agree to allow UnitedHealthcare* to share my protected health information (PHI) to the person or company listed below.

Part A: Individual's information

Last name: First name: MI:

DOB (MM/DD/YYYY): Address:

City: State: ZIP code:

Phone number (with area code):

Email address:

ID number (See ID card):

Group number (See ID card):

Part B: Person who will get my information

This person is authorized to get my information. I understand once disclosed, my information is shared, it may no longer be protected by federal privacy laws and might be further shared without my permission.

Last name: First name: MI:

DOB (MM/DD/YY)(Optional):

Relationship to member/patient:

Address:

City: State: ZIP code:

Phone number (with area code):

Email address:

Part C: Description of information to be shared

I authorize the following information to be shared. **Select one of the options below.**

○ **All my information**. This may include information about alcohol or substance use disorders, genetic information, HIV/AIDS, infectious diseases, mental or behavioral health and reproductive health; **OR**

○ **All my information EXCEPT the categories selected below.** If I do not check a box, all information will be selected.

- ○ Alcohol or substance use disorders
- ○ HIV/AIDS
- ○ Reproductive health
- ○ Genetic information
- ○ Mental or behavioral health
- ○ Infectious diseases

○ I authorize only the sharing of the following information:

Part D: Purpose of disclosure

○ My health information is being shared at my request or at the request of my personal representative; **OR**

○ My health information is being shared for the following purpose:

Part E: Expiration

I understand this authorization will expire 24 months from the date of my signature unless I provide an earlier date below or am a resident of a state requiring a shorter time limit.

Date sooner than 24 months (MM/DD/YYYY):

Part F: Signature

I understand and agree that signing this form:

- Is voluntary.
- Not signing this form will not impact my ability to get treatment, payment for health care services, or health care benefits I am entitled to.
- I can end this authorization at any time by notifying UnitedHealthcare in writing. I understand that ending this authorization will not affect any sharing of my information that has already happened.

Signature: Date (MM/DD/YYYY):

Witness Signature (For Illinois Residents Only): Date (MM/DD/YYYY):

Personal representatives

If you are a parent, note that below. For all other types of legal authority, you must include documentation (for example, Power of Attorney, Guardianship, etc.) of your legal authority to act as a Personal Representative.

I agree that by signing this form, I have the legal authority to act for the Individual. If I am not the parent of a minor child, I am attaching legal documents to this request. I understand that not submitting any required documents will make this form incomplete. If you are making this request for a minor child, we may need more information before this request will be processed.

Please complete the following:

Legal representative (print full name):

Legal relationship to individual:

Address:

City: State: ZIP code:

Signature: Date (MM/DD/YYYY):

Keep a copy of this form for your records. Send the signed and completed form to:
UnitedHealthcare, Attn: Shared Access Ops, PO Box 6, Huntingdon Valley, PA 19006 or fax to: 1-877-875-0797.

United Healthcare®

*UnitedHealthcare and its subsidiaries, affiliates, employees, agents, and subcontractors, including Optum Behavioral Health, Optum Rx retail/pharmacy benefits, and Optum Health.

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Instructions for Completion of HIPAA Authorization for the Use and Disclosure of Health Information Form

Part A. Individuals Information	Fill in your name, date of birth, address, phone number, email address, ID number and Group ID (see your card). This information is required for identification and authentication purposes.
Part B. Person or Company who will receive my information	Write the name, date of birth, relationship, address, phone number and email address of the individual(s) that you authorize UnitedHealthcare to disclose information to regarding your care. Do not list yourself. This information is required.
Part C. Description of Information to be disclosed	Place a check mark in **one** of the applicable boxes. If the third box is checked write on the line provided the specific information we may disclose.
Part D. Purpose of Disclosure	Place a check mark in **one** of the applicable boxes. If the second box is checked write on the line the specific purpose of the disclosure of your information.
Part E. Expiration	If not filled in, authorization will expire in 24 months. If you prefer an expiration date prior to 24 months, please indicate that date.
Part F. Signature	Please sign and date the form. This is required. If you reside in Illinois, you are required to have a witness signature.
Personal Representatives	A personal representative who signs on the individual's behalf must provide legal documentation to verify their authority to do so. This can include a power of Attorney, Guardianship, etc. Please include any necessary letters of incapacity. Write personal representatives name, relationship to the individual, address and sign and date the form.