Optum

Authorization for Release of Health Information

Member's Full Name	Date of Birth	Member #	
Member's Street Address	City	State	ZIP Code

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 Optum® 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 Optum and its affiliates to receive from or disclose my individually identifiable health information to the following person(s) or 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:

☐ 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; **or**

☐ I authorize only the disclosure of the following information:

_____

(Type of Information)

Purpose of disclosure:

- ☐ My health information is being disclosed at my request or at the request of my personal representative; **or**
- ☐ My health information is being disclosed for the following purpose:

_____

(Explain Purpose)

_____ _____

Signature of Member Date

_____ _____

Witness Signature *(For Illinois Residents Only)* Date

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 Individual's Representative Date

Personal Representative's:

_____ _____

Name Phone Number

_____ _____ _____ _____

Street Address City State ZIP Code

(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

Optum

Instructions for completing the Authorization for Release of Information

1. Personal Information (such as “Members full name” and “Date of birth”)	Write your name, date of birth, address and member ID.
2. Who may receive and disclose my information:	Write the names and addresses of the people that you want to get information to about your care.
3. Type of information to be disclosed	Place a checkmark next to the kind of information you want us to share. If you check the second box, write the kind of information you want us to share.
4. Purpose of disclosure	Place a checkmark next to the reason you want us to share your information. If you check the second box, write the reason you want us to share your information.
5. Signature of member	This form must be signed and dated.
6. Personal representative	You can choose someone to sign this form for you. They must send us information proving they have your permission.

Please return completed forms to the address below.

Attn: ROI Processing
11000 Optum Circle
MN 103-0600
Eden Prairie, MN 55344
or
Fax to: 1-866-322-0051