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

I authorize Optum* 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 _____

*For purposes of this Authorization, "Optum" refers to the following Optum entities and respective subsidiaries, affiliates, and business divisions: United HealthCare Services, Inc.; Specialized Care Services, Inc.; Spectera, Inc.; Spectera of New York, IPA, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; United Resource Networks, Inc.; Special Risk International, Inc.; United Resource Networks IPA of New York, Inc.; EnvisionCare Alliance, Inc.; Specialty Resource Services, Inc.; National Benefit Resources, Inc.; Medical Network, Inc. d/b/a Health A to Z; DCG Resource Options, LLC; Disability Consulting Group, LLC; HealthAllies, Inc.; Distance Learning Network, Inc.; PacificDental Benefits, Inc.; Pacific Union Dental, Inc.; Nevada Pacific Dental; PacifiCare Dental; National Pacific Dental, Inc.; NPD Dental Services, Inc.; NPD Insurance Company, Inc.; ACN Group, Inc.; Managed Physical Network, Inc.; ACN Group IPA of New York, Inc.; ACN Group of California, Inc.; Dental Benefit Providers, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; DBP Services of New York IPA, Inc.; Dental Benefit Providers of Maryland, Inc.; United Behavioral Health; U.S. Behavioral Health Plan, California; Behavioral Health Administrators; United Behavioral Health of New York, I.P.A., Inc.; PacifiCare Behavioral Health, Inc.; and PacifiCare Behavioral Health, Inc., of California.

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 Optum 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
(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 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. Authorization terminates upon the earlier termination of policy coverage, or 60 days after the termination of treatment.

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.