AUTHORIZATION TO RELEASE INFORMATION - One year or as specified
Note: Your enrollment in a health plan, eligibility for benefits, processing and payment of claims, or treatment is not conditioned upon giving this Authorization.

Member Name: _____

ID# (Number on ID card):_____

Date of Birth: _____ / _____ / _____ S.S.N.: _____ -_____- _____ Phone: _____ - _____ - _____

Evening Phone: _____ – _____ – _____ Email Address:_____

Address: _____

City: _____ State:_____ Zip: _____

AUTHORIZATION TO RELEASE AND DISCLOSE INFORMATION & RECORDS
I authorize the release and disclosure of information or records as follows:
I authorize UnitedHealth Group Inc. and any of its subsidiaries ("UnitedHealth Group") to release, disclose, or deliver the information or records described below to: _____

whose address is: _____

City: _____ State:_____ Zip: _____

DATES OF THE INFORMATION OR RECORDS THAT MAY BE RELEASED
The dates of the information or records I hereby authorize to be released, disclosed, or delivered are (complete by placing a check mark on the appropriate line):
____ All dates of service or anything related to all dates of service
____ The following dates of service or anything related to the following dates of service: ____ / ____ / _____ – ____ / ____ / _____

METHOD OF DISCLOSURE
The method of disclosure is (complete by placing a check mark on the appropriate line):
____ Discussions with UnitedHealth Group staff (only)
____ Discussions with UnitedHealth Group staff and, if necessary, paper copies mailed
____ Paper copies (only) mailed upon processing this Authorization and upon any subsequent request

PURPOSE OF THE DISCLOSURE
The purpose for this Authorization is (complete by placing a check mark on the appropriate line):
____ To provide information or records to the person or entity named above at my request, or
____ Please explain other purpose: _____

EXPIRATION DATE OF AUTHORIZATION
UnitedHealth Group is authorized to release, disclose, or deliver the specified information or records for one year after the signature date set forth below. If an earlier expiration date is preferred, specify the earlier expiration date: ____ / ____ / _____ . (If member is a minor, the Authorization expires on the member's 18th birthday, if earlier than the above expiration date.)

By my signature below, I specifically authorize UnitedHealth Group to release, disclose, and deliver the above-specified information or records in its possession to the above-specified person or entity, which may include confidential information or records pertaining to mental health treatment (excluding mental health therapist notes), substance abuse treatment, HIV-related information, genetic testing information, and any other information or records afforded confidential treatment by federal and/or state law.

I SPECIFICALLY AUTHORIZE AND CONSENT TO THIS DISCLOSURE AND I HAVE READ THE FRONT AND BACK OF THIS AUTHORIZATION.

Signature:_____ Date:____ / ____ / 20_____

OR INSTEAD

If this request is authorized by a parent/guardian on behalf of a minor child or by a legal representative, please complete the following instead of the above signature:
Signature of parent, guardian, or legal representative:_____ Date:____ / ____ / 20_____

Printed name of parent, guardian, or legal representative:_____ Daytime phone:_____-_____-_____

Age of minor:_____ Relationship to member or authority to act on member's behalf: _____

(If this request is made by a legal representative on behalf of the member, a copy of the legal representative's authority or Power of Attorney must be attached if it is not already on file with UnitedHealth Group.)

PLEASE MAINTAIN A COPY OF THIS AUTHORIZATION

……..

For UnitedHealth Group purposes only
Sent by:_____ Date:____ / ____ / 20_____ Location:_____

NOTICES AND ACKNOWLEDGEMENTS

REVOCATION RIGHT: I understand that I have a right to revoke this Authorization in writing at any time. Any revocation must be delivered to the individual or organization listed below. I understand that the revocation will be effective only after UnitedHealth Group's receipt and processing of it, except to the extent UnitedHealth Group has taken steps in reliance upon this Authorization before receipt of the written revocation.

Please send revocations to:

_____

_____

_____

RE-DISCLOSURE NOTICE: I understand that information or records disclosed pursuant to this Authorization may be re-disclosed by the recipient and will no longer be protected by federal law, unless the recipient is a covered entity under federal privacy regulations or has signed an agreement with UnitedHealth Group as a Business Associate, pursuant to federal privacy regulations.

ACKNOWLEDGEMENT OF RECEIPT OF COPY OF AUTHORIZATION: I acknowledge that I have received a copy of this Authorization.

CHARGES: UnitedHealth Group reserves the right to charge, as permitted by law, for the information or records produced pursuant to this Authorization. I agree to pay these charges.

COPY AS ORIGINAL: I understand that a copy or facsimile (fax) is valid as an original.

FEDERAL AND/OR STATE LAWS AND RE-DISCLOSURE

If my information or records contain information regarding mental health treatment, substance abuse treatment, or HIV-related information, I understand that such information or records may be protected under federal and/or state law. Federal regulations require any disclosure or re-disclosure of such information or records to be accompanied by the following statement:

> This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Applicable law may provide me with a right to inspect any such records released, disclosed, or delivered pursuant to this Authorization at any time.

State and/or federal law provide that I may have a right to prohibit re-disclosure of confidential medical information or records and further disclosure may not occur without my express written permission, except:

- if litigation/arbitration is involved, the recipient may, without further authorization, re-disclose any and all information or records released or disclosed to parties, their legal counsel, experts or potential experts, insurers, my health care providers, anyone against whom I have made a claim, administrative agencies, the court or arbitration service and its personnel and officers, any person authorized by law or the court or arbitrator (including but not limited to persons attending proceedings), and any agents or employees of said persons.
- upon other occasions as permitted by law.