



Dear Member:

To facilitate the coordination of your care we may need to discuss your health information with an individual that you designate, or acquire health information from a third party. Before we can do so, you will need to complete and sign the enclosed Authorization for Release of Information form and include all necessary documentation.

Please complete, sign, and date the enclosed form. Once you have completed the form in its entirety and attached any legal documentation necessary please return the form to:

Optum ROI Processing Fax: 1-866-322-0051

OR

Optum
ROI Processing
13655 Riverport Drive
Maryland Heights, MO 63043

Your prompt attention in this matter is greatly appreciated.

Sincerely,
Optum



Authorization for Release of Health Information

_____	_____	_____	
Individual's Full Name	Date of Birth	Member or Subscriber ID #	
_____	_____	_____	_____
Individual'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 disclose my individually identifiable health information to the following person(s) 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 Individual

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



Instructions for Completion Authorization for Release of Information

1. Demographical Information	Fill in your name, date of birth, address information and your subscriber ID. This information is required for identification and authentication purposes.
2. I authorize Optum and its affiliates to disclose my individually identifiable health information to the following person(s) or organization(s):	Write the name and address of the individual(s) that you authorize Optum to disclose information to regarding your care.
3. Type of Information to be Disclosed	Place a check mark in one of the applicable boxes. If the second box is checked write on the line provided the specific information we may disclose.
4. 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.
5. Signature of Individual	To be valid the authorization form must be signed and dated. For Illinois consumers, a witness signature is required.
6. Personal Representatives	A personal representative who signs on the individual's behalf must provide legal documentation to verify his/her authority to do so.