

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION

This authorization must be written, dated and signed by the consumer or by a person authorized by law to give this authorization. File copy and facsimile transmission are considered equivalent to the original. If _____ seeks the authorization from an individual for a use or disclosure of PHI, _____ must provide the individual with a copy of the signed authorization.

I authorize _____, and its subsidiaries/affiliates, to use or disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities, including health care providers as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services, reproductive health services, and treatment for sexually transmitted diseases.

I understand that the information I authorize a person or entity may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/entities authorized to receive the information:

2. Type of information we are authorized to disclose:

3. The information will be used or disclosed for the following purposes: *(If the consumer is requesting the use or disclosure for his/her own purposes, the purpose may be described as "at the request of the individual.)*

4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my enrollment in the health plan, eligibility to receive benefits, ability to obtain treatment, or ability to receive payment unless allowed by law. *(Only applicable if _____ is requesting the information for its own uses and disclosures. Otherwise, delete #4 in its entirety and renumber remaining provisions.)*

5. I understand that I may revoke this authorization at any time by notifying _____ in writing at [insert address], except to the extent that:

- (a) We have taken action in reliance on this authorization; or
- (b) If authorization was obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

6. This authorization expires [on] [upon]

_____. *(Insert applicable date or event. May insert the statement "one year from the date indicated below." The statement "end of the research study," "none," or similar language is sufficient if the authorization is for _____ to use or disclose information for research, including the creation and maintenance of a research database or research repository.)*

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- 7. UnitedHealthcare will/will not (select one) receive compensation for using or disclosing this information. *(Only applicable to authorizations required for marketing. If authorization is not for marketing, delete item #7 in its entirety.)*

Printed name of consumer or consumer's representative to act for consumer	Relationship to consumer and authority
Consumer Identification Number	Consumer address and phone number
Signature of consumer	Date