All Savers instructions for completion of Authorization for Release of Health Information

1 Demographical information

Fill in your name, date of birth, address information and your subscriber ID. This information is used for identification and authentication purposes.

2 I authorize UnitedHealthcare and its affiliates to receive from or 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 UnitedHealthcare 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, on the line provided, write 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, on the line provided, write the specific purpose of disclosure of your information.

5 Signature of member

To be valid, the authorization form must be signed and dated. For members residing in Illinois, a witness signature is required.

6 Personal representatives

A personal representative who signs on the member's behalf must provide legal documentation to verify his or her authority to do so.

continued

All Savers
Authorization for Release of Health Information

Plan participant's full name	Date of birth	Plan participant or subscriber ID no.	
Plan participant'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 disorder services, 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; and
- This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare 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 UnitedHealthcare and its affiliates to receive from or 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 disorder services, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; or
- ◯ I authorize only the disclosure of the following information:

Type of information

continued

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 plan participant | 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 and complete the following:

Guardian or representative:

Name | Phone number

Street address | City | State | ZIP code

Signature of guardian or representative | Date

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 FORM FOR YOUR RECORDS AND RETURN IT TO:

All Savers Insurance Company
Attn: Imaging Department
P.O. Box 31373
Salt Lake City, UT 84131-0373

or

Fax: 1-844-879-7295

Administrative services may be provided by United HealthCare Services, Inc. and its affiliates for insurance products underwritten by All Savers Insurance Company.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop loss insurance is underwritten by All Savers Insurance Company (except MA, MN, NJ and NY), UnitedHealthcare Insurance Company in MA and MN, UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

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