UnitedHealthcare®

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 used for identification and authentication purposes.
2. I authorize UnitedHealthcare and its affiliates to receive from or disclose my individually identifiable healthinformation 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, 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 disclosure of your information.
5. Signature of Member	To be valid the authorization form must be signed and dated. For Illinois member, 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/her authority to do so.

AUTHORIZATION FOR RELEASE OF INFORMATION

Member's Full Name | Date of Birth | Member or Subscriber ID No.

Member'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; 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 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 Member | 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
PO Box 31373
Salt Lake City, UT 84131-0373
or
FAX: 1-920-661-9959

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