[Document Name: Authorization Form to Use & Disclosure PHI]
[Used for: When an individual or functional area identifies the need to use or disclose an enrollee's protected health information for non-treatment, payment, or health care operations activities or activities that require an authorization under the HIPAA regulations]
[Used by: Customer Service/Call Centers, IRG]

Enrollee full name_____ **Enrollee ID:** _____

Enrollee address _____ **Group Number:**

Enrollee city, state, zip_____

PERMISSION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
(AUTHORIZATION)

You must complete both sides of this form. If you have a legal representative, they can complete this form for you. A fax of this form is the same as the original. When we get your form back, we will mail you a copy.

I allow [United Healthcare Services, Inc., on behalf of itself and related companies] to use or give out my medical, claim and benefit records. These records may include personal health information. These records may have information created by others. These records may have information on specific treatment or services you have received. These records may also include mental health services but psychotherapy notes may be given out only with separate permission.

1. Those permitted to get the information:

<For internal (UHG/Ovations/UnitedHealthcare) requests, prefill response>_____

_____

2. Type of information [United Healthcare Services, Inc.] may use or give out:

_____

_____

3. The information will be used or given out for:

_____

_____

4. I may end this permission at any time. I must put it in writing. I can call Customer Service for a form. I can end this except,
   a. if [United Healthcare Services, Inc.] has already acted on my permission; or
   b. if I gave permission to [United Healthcare Services, Inc.] to review my request for insurance, and other law provides the insurance company the right to not pay a claim under the policy.

5. This permission expires [on] [upon] _____[date] or _____[event] or until [United Healthcare Services, Inc.] receives my form which ends permission to use or give out my medical information.

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6. [United Healthcare Services, Inc.] will not get paid from a third party for using or giving out this information.

7. This permission is voluntary. I may refuse to sign this. If I refuse to sign, it will not affect my health benefits.

I know that once health information about me has been given out by [United Healthcare Services, Inc.] to a third party, the health information may not be protected by federal privacy laws.

_____ _____

Print your name **Sign your name**

_____ _____

Witness: Print your name **Sign your name**
(A witness signature is only needed if the enrollee signs with an "X" due to physical limitations, illiteracy, or other reasons)

PERSONAL REPRESENTATIVE INFORMATION:

Name _____

Address_____

City_____**State** ____**Zip** _____**Telephone**_____

Relationship to member: Spouse Child Personal Representative Other_____

Signature of representative:

X _____ **Date**_____

Important: Guardians, court appointed representatives or other responsible parties must send a copy of legal documents proving that they have legal authorization, if we have not already received this information.

_____

Date