OPTUM®

Patient name: _____
MR# _____ DOB: ____ / ____ / ____
Address: _____
City: _____ State: _____
ZIP: _____ Phone #: (____) _____
Email: _____

Authorization for disclosure of protected health information

OptumCare® and its entities will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

This authorizes the following OptumCare clinic(s)/affiliate(s): _____

_____

_____

to disclose information as specified below for the following purpose(s):

☐ Personal ☐ Legal ☐ Insurance purposes

☐ Continued medical care

☐ Other _____

OptumCare may disclose this information to:

☐ *Check if same as above (disclosure to patient)*

Recipient

Name: _____

Address: _____

City: _____

State: _____ ZIP: _____

Phone #: (____) _____ Fax #: (____) _____

Email: _____

Copies of records or medical record information within the following dates: _____ to _____

☐ Medical office/Clinical records ☐ Hospital records ☐ All records for specified physician or facility/clinic

☐ Records limited to a specific provider _____ or Department: _____

☐ X-ray films ☐ X-ray digital images ☐ Laboratory results ☐ Billing/Claims information

Note: Hospital and medical office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.

The actual treatment records from restricted or sensitive health information are specifically protected, and will not be disclosed unless you sign below.

Mental/behavioral Health records - Signature: _____
Alcohol/drug dependency treatment records - Signature: _____
HIV testing results/AIDS treatment - Signature: _____
Sexually transmitted disease (STD) - Signature: _____
Genetic testing/test results - Signature: _____

Media type: ☐ Electronic ☐ Paper **Delivery preference:** ☐ Email/secure portal/encrypted ☐ US Mail ☐ Pick-up

Duration: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here ____/____/____ (date).

Revocation: Patient or Personal Representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

Re-disclosure: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before disclosing this information.

Fee disclaimer: Federal and state laws permit OptumCare to charge a reasonable fee for copying/releasing records. State regulated fees for labor and supplies may apply. You will be notified in advance regarding any fees and payment as required. A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

Date _____ Signature _____ If not the patient, print your name and relationship. Verification of right to request, if not patient, e.g. legal documentation, required. _____

Office use only: Date received: ____/____/____ Received by (Print name/Initial): _____/____