Authorization to Share Personal Information

Please send completed form to:
UnitedHealthcare
P.O. Box 29200
Hot Springs, AR 71903-9200
[Or fax to: <1-501-262-7070>]

I am requesting UnitedHealthcare Insurance Company (UIC), on behalf of itself and related companies, to release my personal health information, including medical, claim and/or benefit records, to _____.
(Recipient's Name – please print)
These records may have information on specific treatment or services I have received. These records may have information created by others.

This Authorization to Share Personal Information Form allows UnitedHealthcare Insurance Company (UIC), on behalf of itself and related companies, to discuss or give out your personal health information to a person you select. The Health Insurance Portability and Accountability Act (HIPAA) requires us to get your permission before we release your information.

SECTION 1: Member Information

Member Name (please print)	Member ID Number

Permanent Address (City, State, ZIP Code)

Telephone Number	E-mail Address (optional)*

SECTION 2: Expiration and Revocation

I understand that:
1) This authorization expires on my last day as a member of the plan or until UIC receives my written request to end this authorization.
2) I may end this authorization at any time. I must do so in writing. I must send my written request to the health plans. I can find plan contact information in my Evidence of Coverage. If UIC has already released any of my personal health information before it receives my written request, my request will not cancel out any requests for information made prior to receiving the written request.
3) This permission is voluntary. I may refuse to sign this form. If I refuse, it will not affect my health benefits.
4) Once health information about me has been given out, it could be redisclosed and it may not be protected by federal privacy laws.

Member Name (please print)

Member Signature	Date

(over please)

SECTION 2 (continued)	
A witness signature is needed only if the member signs with an "X" due to physical limitations, illiteracy or other reasons. The witness should be someone other than the person/entity named above.	
Witness Name (please print)	
Witness Signature	Date

SECTION 3 (optional): Recipient of Information	
Recipient's Name	
Permanent Address (City, State, ZIP Code)	
Telephone Number	Relationship to Member
E-mail Address (optional)*	

Personal Representative Information	
Name	
Address (City, State, ZIP Code)	
Telephone Number	Relationship to Member: Power of Attorney Guardian Conservator Other _____
Representative Signature	Date

*By providing an e-mail address, you are allowing UIC to send you occasional plan updates. UIC does not sell or share information to companies outside of our UnitedHealth Group organization. You can opt out of these e-mails at any time.

Please Note: This authorization does not allow the person/entity named above to change the plan you are enrolled in, to represent you in a claims appeal, or to make any of your treatment decisions or direct care decisions. If you want someone to make health care and treatment decisions on your behalf, you will need additional legal documentation and will be required to submit a different form.