Authorization for Release of Health Information

Follow these instructions to complete the form.

Member's personal information

Write your full name, date of birth, address and member/subscriber ID in this section.

Who may get and share my information

Write the full name and address of the person(s) or organization(s) you are allowing to get information from or share information with.

Type of information to be shared

Check one of the boxes. If you check the second box, write what information we may share.

Purpose of disclosure

Check one of the boxes. If you check the second box, write the purpose of the release of information.

Signature

To be valid, the form must be signed and dated. Illinois members also need the signature of a witness.

Personal representative

If you have a guardian or court appointed representative, they must complete this section. They will also need to attach a copy of their legal proof of authority.

Authorization for Release of Health Information

Please keep a copy of this form for your records.

Member's personal information

Full name _____

Address _____

City _____ State _____ ZIP _____

Member/Subscriber ID _____ Date of birth _____

I understand and agree that:

- This authorization is voluntary.
- My health information may be from third parties. This may include health care providers. It may be these types of information:
    - Medical records
    - Pharmacy
    - Dental records
    - Vision care
    - Mental health
    - Substance abuse care
    - HIV/AIDS
    - Psychotherapy
    - Reproductive care
    - Communicable disease
- I may not be denied treatment or payment for health care if I don't sign this form. I may not be denied eligibility for health care if I don't sign this form.
- My health information may be shared by the recipient. If the recipient is not a health plan or provider, the information may not be protected by the federal rules.
- This permission will expire 1 year from the date I sign it. I may cancel it at any time. To do so, I must tell UnitedHealthcare in writing. The revocation will not have an effect on any actions prior to the date it is processed.

Who may get and share my information

I give permission for UnitedHealthcare and its affiliates to get from or share my health information with:

_____

Full name of person(s) or organization(s)

_____

Full name of person(s) or organization(s)

Type of information to be shared

Check one of the boxes.

☐ I authorize disclosure of all my health information. This includes these types of information:

- Medical records
- Pharmacy
- Dental records
- Vision care
- Mental health
- Substance abuse care
- HIV/AIDS
- Psychotherapy
- Reproductive care
- Communicable disease

☐ I authorize only the disclosure of the following information:

_____

Purpose of disclosure

Check one of the boxes.

- ☐ My health information is being shared at my request or at the request of my representative.
- ☐ My health information is being shared for this purpose:

_____

Signature

_____ _____

Signature of member Date

_____ _____

Witness signature (*For residents of Illinois only*) Date

Personal representative

If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

Personal representative's name _____

Address _____

City _____ State _____ ZIP _____

Phone number _____

_____ _____

Signature of member's representative Date

Ready to send the completed form?

Send the signed and completed form to:

UnitedHealthcare Community and State

PO Box 30753
Salt Lake City, UT 84130

Fax: 1-844-386-9286

Please keep a copy of this form for your records.

Civil Rights Notice

Discrimination is against the law. Rocky Mountain Health Plans complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation.

Rocky Mountain Health Plans provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Rocky Mountain Health Plans provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call Member Services at **1-800-421-6204** (TTY/TDD **711**).

If you believe that Rocky Mountain Health Plans has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation, you can file a grievance with:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: **ocrportal.hhs.gov/ocr/portal/lobby.jsf**

By mail:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

By phone: **1-800-368-1019** (TDD: **1-800-537-7697**)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

1-800-421-6204, TTY 711

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the toll free number above.

Español: ATENCIÓN: Si habla español, los servicios de asistencia de idiomas están disponibles para usted sin cargo. Llame al número de teléfono gratuito que se indica arriba.

Tiếng Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số điện thoại miễn phí ở trên.

中文： 注意：如果您說中文，您可獲得免費語言協助服務。撥打上方免費電話。

한국어: 참고: 한국어를 구사하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. 상기 수신자 부담 전화번호로 전화하십시오.

Русский: ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете бесплатно воспользоваться помощью переводчика. Позвоните по указанному выше бесплатному номеру.

አማርኛ:- ትኩረት:- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች፣ በነጻ ክፍያ፣ ለእርስዎ ይገኛሉ። ከላይ ባለው ከክፍያ ነጻ ቁጥር ይደውሉ።

العربية: تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوفر لك مجانًا. اتصل بالرقم المجاني أعلاه.

Deutsch: HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Rufen Sie die oben aufgeführte kostenfreie Nummer an.

Français : ATTENTION : si vous parlez français, vous pouvez obtenir une assistance linguistique gratuite. Composez le numéro gratuit ci-dessus.

नेपाली: ध्यान दिनुहोस: तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। माथिको टोल

Tagalog: PANSININ: Kung nagsasalita ka ng Tagalog, may magagamit kang libreng mga serbisyong pantulong sa wika. Tawagan nang libre ang numero sa itaas.

日本語: 注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。上記のフリーダイヤル番号までお電話ください。

Afaan Oromoo: XIYYEEFFANNOO: Afaan Oromoo dubbattu yoo ta’e, tajaajilli gargaarsa afaanii, kaffaltii malee isiniif ni argama. Lakkoobsa waamicha bilisaa armaan olii irratti bilbilaa.

فارسی: توجه: اگربه زبان فارسی صحبت می‌کنید، خدمات ترجمه زبان به صورت رایگان به شما ارائه خواهد شد. با شماره رایگان بالا تماس بگیرید.

Polski: UWAGA: Jeżeli mówisz po polsku, dostępne są bezpłatne usługi wsparcia językowego. Zadzwoń pod darmowy numer podany powyżej.