

# Authorization for release of health information

Member's full name:		Date of birth:
Member or subscriber ID#:		
Member's street address:		
City:	State:	ZIP code:
<b>I understand and agree that:</b> <ul style="list-style-type: none"><li>• This authorization is voluntary;</li><li>• 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;</li><li>• 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;</li><li>• 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;</li><li>• This authorization will expire 1 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.</li></ul>		
<b>Who may receive and disclose my information</b>		
I authorize UnitedHealthcare and its affiliates to receive from or disclose my individually identifiable health information to the following person(s) or organization(s):		
<b>Full name of person(s) or organization(s):</b>		
Full address of person(s) or organization(s):		
<b>Full name of person(s) or organization(s):</b>		
Full address of person(s) or organization(s):		
<b>Full name of person(s) or organization(s):</b>		
Full address of person(s) or organization(s):		
<b>Full name of person(s) or organization(s):</b>		
Full address of person(s) or organization(s):		



**Type of information to be disclosed** (Choose 1 option)

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** (Choose 1)

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:

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:**  
Rocky Mountain Health Plans  
2775 Crossroads Blvd.  
Grand Junction, CO 81506

