HIPAA Authorization for the Use and Disclosure of Health Information

By completing and signing this form, I, or my personal representative, agree to allow UnitedHealthcare* to share my protected health information (PHI) to the person or company listed below.

Part A: Individual's information

Last name: First name: MI:

DOB (MM/DD/YYYY): Address:

City: State: ZIP code:

Phone number (with area code):

Email address:

ID number (See ID card):

Group number (See ID card):

Part B: Person who will get my information

This person is authorized to get my information. I understand once disclosed, my information is shared, it may no longer be protected by federal privacy laws and might be further shared without my permission.

Last name: Legal-Ease Digital Imaging First name: Pat Clifford MI: A

DOB (MM/DD/YY)(Optional):

Relationship to member/patient: Record Retrieval Company

Address: 2496 Meadowcroft Dr

City: Burton State: Michigan ZIP code: 48519

Phone number (with area code): 855-543-4003

Email address: pat.legalease@gmail.com

Part C: Description of information to be shared

I authorize the following information to be shared. **Select one of the options below.**

○ **All my information**. This may include information about alcohol or substance use disorders, genetic information, HIV/AIDS, infectious diseases, mental or behavioral health and reproductive health; **OR**

○ **All my information EXCEPT the categories selected below.** If I do not check a box, all information will be selected.

- ○ Alcohol or substance use disorders
- ○ HIV/AIDS
- ○ Reproductive health
- ○ Genetic information
- ○ Mental or behavioral health
- ○ Infectious diseases

○ I authorize only the sharing of the following information:

Part D: Purpose of disclosure

○ My health information is being shared at my request or at the request of my personal representative; **OR**

○ My health information is being shared for the following purpose:

Part E: Expiration

I understand this authorization will expire 24 months from the date of my signature unless I provide an earlier date below or am a resident of a state requiring a shorter time limit.

Date sooner than 24 months (MM/DD/YYYY):

Part F: Signature

I understand and agree that signing this form:

- Is voluntary.
- Not signing this form will not impact my ability to get treatment, payment for health care services, or health care benefits I am entitled to.
- I can end this authorization at any time by notifying UnitedHealthcare in writing. I understand that ending this authorization will not affect any sharing of my information that has already happened.

Signature: Date (MM/DD/YYYY):

Witness Signature (For Illinois Residents Only): Date (MM/DD/YYYY):

Personal representatives

If you are a parent, note that below. For all other types of legal authority, you must include documentation (for example, Power of Attorney, Guardianship, etc.) of your legal authority to act as a Personal Representative.

I agree that by signing this form, I have the legal authority to act for the Individual. If I am not the parent of a minor child, I am attaching legal documents to this request. I understand that not submitting any required documents will make this form incomplete. If you are making this request for a minor child, we may need more information before this request will be processed.

Please complete the following:

Legal representative (print full name):

Legal relationship to individual:

Address:

City: State: ZIP code:

Signature: Date (MM/DD/YYYY):

Keep a copy of this form for your records. Send the signed and completed form to:
UnitedHealthcare, Attn: Shared Access Ops, PO Box 6, Huntingdon Valley, PA 19006 or fax to: 1-877-875-0797.

United Healthcare®

*UnitedHealthcare and its subsidiaries, affiliates, employees, agents, and subcontractors, including Optum Behavioral Health, Optum Rx retail/pharmacy benefits, and Optum Health.

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