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:

I understand and agree that:

- This authorization is voluntary;
- 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;
- 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;
- 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;
- This authorization will expire one 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.

Who may recieve and disclose my information

I authorize UnitedHealthcare and its affiliates to receive from or disclose my individually identifiable health information to the following person(s) or organization(s):

(Full Name of Person(s) or Organization(s)):
(Full Address of Person(s) or Organization(s)):
(Full Name of Person(s) or Organization(s)):
(Full Address of Person(s) or Organization(s)):
(Full Name of Person(s) or Organization(s)):
(Full Address of Person(s) or Organization(s)):
(Full Name of Person(s) or Organization(s)):
(Full Address of Person(s) or Organization(s)):

Type of information to be disclosed (choose one 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 one)

☐ 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

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