



Authorization for Release of Information

Member's Name	Date of Birth	<input type="checkbox"/> Member or Subscriber ID#	<input type="checkbox"/> Chart #
Member's Street Address	City	State	Zip Code

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying UnitedHealthcare in writing. However, the revocation will not have an effect on any actions UnitedHealthcare took before it received the revocation.

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

Name: Medical Research Consultants (MRC)

Address: 1336 Brittmore Road, Suite 100

<u>Houston</u>	<u>TX</u>	<u>77043</u>
City	State	Zip

Phone Number: (888) 868-6769 **Extension**

Description of individually identifiable health information to be received or disclosed (check appropriate type(s) of information):

- | | |
|---|--|
| <input type="checkbox"/> All | <input type="checkbox"/> Treatment Plan(s) |
| <input type="checkbox"/> Claims | <input type="checkbox"/> Progress Reports |
| <input type="checkbox"/> Eligibility/Benefits | <input type="checkbox"/> Attendance Only |
| <input type="checkbox"/> Information used to make benefit determinations | |
| <input type="checkbox"/> All pertinent information UnitedHealthcare deems appropriate for the purpose checked below | |
| <input type="checkbox"/> Other (describe): _____ | |

The purpose of this authorization is (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> To allow the appropriate management of treatment, services, and/or coverage under the member's benefit plan. | |
| <input type="checkbox"/> Benefit Management | <input type="checkbox"/> Administration of a Worker's Compensation claim |
| <input type="checkbox"/> Claims Administration/Payment | <input type="checkbox"/> Administration of a Disability claim |
| <input type="checkbox"/> Employer Mandated Treatment Referral | <input type="checkbox"/> Subpoena or other legal process |
| <input type="checkbox"/> Other (describe): <u>Litigation</u> | |

The dates of records to be disclosed:

From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

THE MEMBER OR MEMBER'S REPRESENTATIVE MUST COMPLETE THE REST OF THIS FORM:**I understand that this authorization will expire:**☐ On _____ (MM/DD/YYYY)**OR**☐ Once the following event occurs (*does not apply to Illinois residents*):
_____**(Form must be completed before signing)**_____
Signature of Member/Legal Guardian
or Member's Representative_____
Signature of Minor Member_____
Date**NOTE: If a Legal Guardian or Personal Representative signs this form, please attach documentation supporting guardianship or Representative status.**_____
Print Name of Member/Legal Guardian
or Member's Representative_____
Relationship to Minor Member_____
Description of
Representative's Authority**(For Illinois residents only)** Witness Signature_____
Date of Witness Signature

(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.

(For California and Georgia residents only) A copy of this form has been requested and received:

_____ Yes _____ No

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

Please return the completed form to:

**UnitedHealthcare
Attn: Subpoena Triage
4868 Georgia, Hwy 95, Ste. 203
Forest Park, GA 30297**

PLEASE NOTE THE FOLLOWING STATE-SPECIFIC PROVISIONS:

Arizona: The request must be in writing and signed by the person requesting the medical records. The person requesting the medical records must demonstrate the authority to have access to the records.

California: The patient or the person signing this form has the right to receive a copy of the form. Authorization terminates upon the earlier termination of policy coverage, or 60 days after the termination of treatment.

Georgia: Advises that the individual, or the individual's authorized representative, is entitled to receive a copy of the authorization form.

Illinois: A witness signature is required. The authorization must specify expiration date as a calendar date (i.e., month/day/year). If no calendar date is specified, the information may be released only on the day the consent form is received. Must include right to inspect and copy information to be disclosed. Must also include consequences of refusal to consent, if any. Records do not include information regarding HIV/AIDS status without an authorization that explicitly and specifically includes the release of such information.

Indiana: Expiration of the authorization may be a date, event or other condition. If no expiration is specified, the authorization is valid for 180 days after the date the request was made.

Iowa: The individual has the right to inspect the disclosed information at any time.

Minnesota: Authorization expires on the earlier of the specific date stated or one year from date signed.

Oregon: Unless revoked earlier, the authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

Virginia: To be valid, the authorization must state the inclusive dates of the records to be disclosed.

Washington: Authorization expires on the earlier of the specific date stated or 90 days after signed, including authorization to release future health care information, except information to third party health care payors.