Authorization to Share Personal Information

Please fill out and mail to:
UnitedHealthcare
P.O. Box 29200
Hot Springs, AR 71903-9200
Or fax to: 1-501-262-7070

I am asking UnitedHealthcare Insurance Company (UIC) to provide my personal health information, including medical, claim or benefit records, to:

_____

(Name of person or organization – please print)

These records may contain information on specific medical care or services I received. The records may contain information created by others.

Personal health information is protected by the Health Insurance Portability and Accountability Act (HIPAA).

When I sign this form:

- I give permission to UIC and its related companies
- I give permission for UIC to provide my personal health information to the person or organization named above

SECTION 1: Member Information

Member Name (please print) First, MI, Last

Member ID Number

Permanent Address (City, State, ZIP Code)

Telephone Number

Email Address (optional)*

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SECTION 2: When this permission ends and what happens if I change my mind

How long does this permission last?

Permission to share records ends on your last day as a member of the plan or when you write to us informing it has ended.

Can I change my mind, and "take back" this permission?

You can tell us to stop giving out your information in the future. However, it is not possible to "take back" information you asked us to give out in the past.

How do I end my permission to share my personal health information?

You will need to provide a written request to end your permission and mail or fax it to the health plan. Your Evidence of Coverage has the plan's address and fax number.

What if I refuse to sign this form?

You may refuse to sign. Your health benefits will not be affected.

What happens to my health information after UIC shares it?

UIC cannot control what happens to your information after we share it with the person or organization you named above. At that point, your information may not be protected by HIPAA or federal privacy laws. It could be shared with others.

Member Name (please print) First, MI, Last

Member Signature:	Date
_____	/ /

A witness must sign below if the member can only sign with an "X." The witness can't be the person or organization getting the member's personal health information.

Witness Name (please print) First, MI, Last

Witness Signature:	Date
_____	/ /

SECTION 3 (optional): Information about the person or organization getting the member's personal health information.

Name (please print) First, MI, Last

Permanent Address (City, State, ZIP Code)

Telephone Number

Relationship to Member

Email Address (optional)*

SECTION 4: Personal Representative Information

For members who are unable to sign for themselves. A personal representative is an individual who has the legal right to sign for the member.

Name (please print) First, MI, Last

Address (City, State, ZIP Code)

SECTION 4: Personal Representative Information (continued)

Telephone Number

Relationship to Member

☐ Power of Attorney

☐ Guardian ☐ Conservator ☐ Other _____

Representative Signature:	Date
_____	/ /

*If you give an email address, UIC will send you plan updates from time to time. UIC does not sell or share information to companies outside of our UnitedHealth Group organization. You can tell UIC at any time to stop sending these emails.

Please Note: This form does not give permission to the person or organization named above to:

- Change the plan you are enrolled in, or
- Represent you in a claims appeal, or
- Decide what kind of care you get

If you want someone to have the right to decide your care, you would need a medical power of attorney form.