Golden Rule®

A UnitedHealthcare Company

HOW TO COMPLETE THE AUTHORIZATION FOR RELEASE OF INFORMATION FORM

1. Demographic Information	Fill in your name, date of birth, address information and your member ID. This information is used for identification and authentication purposes.
2. I authorize UnitedHealthcare and its affiliates to receive or release my personal identifiable health information to the following person(s) or organization(s):	Write the name and address of the individual(s) that you authorize UnitedHealthcare to release information to regarding your care.
3. Type of Information to be Released	Mark **one** box only. If the fourth box is checked, write on the line what specific information can be released.
4. Purpose of Release	Mark **one** box only. If you choose the second box, please write the reason for the release.
5. Signature of Member or Parent if under 18 years of age.	To be valid the authorization form must be signed and dated by the member or parent if under 18 years of age. For Illinois members, a witness signature is required.
6. Personal Representatives	A personal representative who signs on the member's behalf must provide legal documentation to verify his or her authority to do so.

44534-G-0916

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AUTHORIZATION FOR RELEASE OF INFORMATION

Member's Full Name	Date of Birth	Member or Subscriber ID No.

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 release by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations; and
- This authorization will expire one year from the date I sign the authorization. I may withdraw this authorization at any time by notifying UnitedHealthcare in writing; however, the withdrawal will not have an effect on any actions prior to the date my cancellation is received and processed.

Who Can Receive and Release my Information:

I authorize UnitedHealthcare and its affiliates to receive from or release my personal and 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)

Type of Information to be Released:

- ❑ I authorize the release 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;
- ❑ I authorize the release of all nonmedical information (including financial information);
- ❑ I authorize the release of both health and nonmedical information; or
- ❑ I authorize only the release of the following information:

Type of Information

Purpose of Release:

- ❑ My health information is being released at my request or at the request of my personal representative; or
- ❑ My health information is being released for the following purpose:

_____
(Explain Purpose)

_____ _____
Signature of Member or Parent if under 18 years of age 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

_____ _____ _____ _____
Street 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:

Golden Rule Insurance Company
Attn: Policy Administration
PO Box 31372
Salt Lake City, UT 84131-0372
or
FAX: 1-801-478-5461