

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.

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: Claims
PO Box 31374
Salt Lake City, UT 84131-0374
or
FAX: 1-801-478-7581