Optum

Authorization to use and disclose protected health information

Optum, on behalf of itself and affiliated companies, uses this form to get your permission to use and/or disclose your protected health information (PHI) to your authorized representative. This authorization does not allow your authorized representative to make any of your treatment decisions or direct care decisions. If you want help with your health care and treatment decisions, you must get additional legal documentation.

Use this form to request authorization for the release of PHI, including patient profile or records, to your authorized representative(s) named below. When filling out this form, provide your most current information.

1. Patient information

Last name

First name

Middle initial

Mailing street address

Apt. #

City

State

ZIP

Date of birth (mm/dd/yyyy)

☐ M ☐ F
Gender

Phone number with area code

Date of injury (mm/dd/yyyy)

2. Authorized representative's information

I authorize Optum to use and disclose my PHI to the person(s) or organization(s) named below. I understand that there are certain parties that must protect the privacy of my PHI. These are health care providers and other parties who are required to do so under federal or related state laws. If my authorized representative is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by my authorized representative without my permission.

Authorized representative #1

Name

Phone number with area code

Mailing street address

Apt. #

City

State

ZIP

Relationship to patient

Authorized representative #2

Name

Phone number with area code

Mailing street address

Apt. #

City

State

ZIP

Relationship to patient

3. Description of information to use or disclose

Please describe the information covered by this authorization.

I understand that by leaving this section blank, I am authorizing the disclosure of all of my PHI, including my patient profile and pharmaceutical records, to my authorized representative(s).

Description:

4. Purpose of disclosure

The purpose of this authorization is to assist me in receiving my health plan benefits and make payments for my health plan benefits. If there are other purposes or reasons for this authorization, they are provided below.

Purpose:

5. Expiration and revocation

I understand that I have the right to end this authorization at any time. I understand that if I do not wish the person(s) named in section 2 to remain my authorized representative, I must cancel this authorization **in writing** and send such notice to the address listed below. I understand that a cancellation of this authorization has no effect on disclosures or uses of PHI by Optum before receiving my cancellation notice.

I understand that this authorization will expire on either the date my claim has terminated (check one) ☐ Yes ☐ No
or the date of my choosing (insert date). _____

If I do not provide an expiration date, I am aware that this authorization is valid for twelve (12) months from the date of my signature as noted below.

6. Authorization and signature of individual or individual's LEGAL representative

I have read and understand the content of this Authorization to Use and Disclose PHI. This authorization correctly describes my request of Optum. I understand that by signing this form, I am voluntarily giving my permission for Optum to use and/or disclose my PHI to the person(s) named in Section 2. Any services otherwise provided to me by Optum will not be affected by my decision to provide this authorization. I may refuse to sign, and Optum will not condition my treatment, payment, enrollment or eligibility for benefits on my decision to sign or not sign this authorization.

Patient signature _____ Date _____

Witness Signature _____ Date _____
(A witness signature is only needed if the patient is unable to sign or the witness is an interpreter)

If this authorization is signed on the patient's behalf by his/her legal representative, please **attach documentation of legal representative designation and complete the following:**

Legal representative's name _____ Date _____

Mailing street address _____ Apt. # _____

City _____ State _____ ZIP _____

Relationship to patient _____

7. Please mail the completed form to:

Optum, Attn: Medical Records PO Box 289, Huntingdon Valley, PA 19006

or email to OptumWC_recordsrequests@optum.com

Please keep a copy of this form for your records. You also have the right to receive a copy of this authorization.