Authorization for Release of Health Information

Member's full name _____

Member's street address _____

City _____ State _____ Zip code _____

Member or Subscriber ID number _____

Date of birth _____

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

Who may receive and disclose my information

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

_____

Full name of person(s) or organization(s)

_____

Full address and/or phone number of person(s) or organization(s)

Type of information to be disclosed

- ☐ I authorize disclosure of all my health information, including information relating to claims, medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information
- ☐ I authorize only the disclosure of the following information:

_____

Type of information

Purpose of disclosure

- ☐ My health information is being disclosed at my request or at the request of my personal representative
- ☐ My health information is being disclosed for the following purpose:

_____

Explain purpose

_____ _____

Signature of member 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.

_____ _____

Signature of member's representative Date

Personal representative's:

Name _____

Street address _____

City _____ State _____ Zip code _____

Phone number _____

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:

- By mail to:
  UnitedHealthcare
  P.O. Box 30753
  Salt Lake City, UT 84130
- By fax at 1-844-386-9286

Language Assistance Services

We[1] provide free language services to help communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call **toll-free 1-877-482-9045** or the toll-free number on your health plan ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 6 p.m. PT.

English
If you need help in another language or you need another format, like large print, please call 1-877-482-9045 or the member number on your health plan ID card, TTY / RTT 711. Translation services and interpreters are available at no cost to you.
Español
Si necesita ayuda en otro idioma o en otro formato, como letra grande, llame al 1-877-482-9045 o al número para miembros en su tarjeta de ID del plan de salud, TTY/RTT 711. Los servicios de traducción y de interpretación están disponibles sin costo para usted.
中文
如果您需要以其他語言提供的協助，或您需要其他形式版本，例如大字體，請致電 1-877-482-9045 或撥打健保計劃會員卡上的會員電話，聽力語言殘障服務專線 / 即時訊息 (TTY / RTT) 711。可免費向您提供翻譯服務和口譯員服務。
Tiếng Việt
Nếu quý vị cần trợ giúp bằng ngôn ngữ khác hoặc quý vị cần định dạng khác, như bản in cỡ lớn, vui lòng gọi đến số 1-877-482-9045 hoặc số điện thoại dành cho hội viên trên thẻ ID chương trình hiểm y tế của quý vị, TTY/RTT 711. Có sẵn các dịch vụ dịch thuật và thông dịch viên miễn phí cho quý vị.
한국어
귀하가 다른 언어로 도움이 필요하거나 큰 활자와 같은 다른 형식으로 필요한 경우, 1-877-482-9045 또는 귀하의 건강보험 ID 카드에 기재된 회원 번호, TTY / RTT 711 번으로 전화하십시오. 귀하는 번역 서비스 및 통역사를 무료로 이용하실 수 있습니다.
Tagalog
Kung kailangan ninyo ng tulong sa ibang wika o kailangan ninyo ng ibang format, tulad ng malalaking titik, pakitawagan ang 1-877-482-9045 o ang numero para sa miyembro na makikita sa inyong ID card sa planong pangkalusugan, para sa gumagamit ng TTY / RTT, tumawag sa 711. Available para sa inyo ang mga serbisyo sa pagsasalin at interpreter nang wala kayong babayaran.
Русский
Если Вам нужна помощь на другом языке или Вы хотели бы получить этот документ в другом формате (например, крупным шрифтом), позвоните по телефону 1-877-482-9045 или по телефону, указанному на Вашей идентификационной карте участника плана медицинского страхования, линия TTY/RTT: 711. Услуги устного и письменного перевода предоставляются бесплатно.
اللغة العربية
إذا كنت بحاجة إلى مساعدة بلغة أخرى أو تحتاج إلى تنسيق آخر مثل الطباعة بأحرف كبيرة، فيرجى الاتصال على رقم 1-877-482-9045 أو رقم هاتف الأعضاء المدرج على بطاقة مُعرف العضوية الخاص بخطتك الصحية، أو TTY/RTT 711. تتوفر خدمات الترجمة التحريرية والمترجمين الفوريين دون أن تتحمل أي تكلفة.

United Healthcare

Français

Si vous avez besoin d’aide dans une autre langue ou souhaitez un autre format, par exemple en gros caractères, veuillez appeler le 1-877-482-9045 ou le numéro d’assuré figurant sur votre carte d’assurance, ATS / RTT (texte en temps réel) 711. Des services de traduction et des interprètes sont disponibles gratuitement.

አማርኛ

በሌላ ቋንቋ እርዳታ የሚፈልጉ ከሆነ ወይም በሌላ ፎርማት የተዘጋጀ ካስፈለግዎት፣ ለምሳሌ በትልቅ የተጻፈ፣ እባክዎን በ 1-877-482-9045 ወይም በኢንሹራንስ ካርድዎ ላይ ባለው የአባል አገልግሎት መስጫ ስልክ ቁጥር ይደውሉ፣ መስማት ለተሳናቸው (TTY/RTT) በ 711። የጽሑፍ ትርጉም አገልግሎት እንዲሁም የቃል አስተርጓሚዎች ምንም ሳይከፍሉ መጠቀም ይችላሉ።

Diné

Ła’ nááná saad bee shika’a’doowoł nínízingo doodago t’áá łahgo át’éego anályaago, nitsaago bee bik’e’ashchʼįįgo da, t’áá shǫǫdí kohjʹ 1-877-482-9045 hod7ilnih doodago nits’íís nánel’įį̀h naaltsoos bee ha’dít’éhígíí bił ninaaltsoos nitł’izí bee nééhizinígíí béésh bee hane’í biká’ígíí bee hodíilnih, TTY / RTT 711. T’áá ni nizaad bee ha’dilyaago dóó atah hane’ígíí t’áá jiik’eh bee ná’agot’i.

فارسی

اگر به زبان دیگری به کمک نیاز دارید یا به فرمت متفاوتی از قبیل چاپ درشت نیاز دارید، لطفاً با شماره 1-877-482-9045 یا شماره مرقوم شده بر روی کارت شناسایی برنامه درمانی خود، TTY / RTT 711 تماس بگیرید .خدمات ترجمه و مترجمین شفاهی بدون اخذ هزینه در اختیار شما می باشند.

اردو

اگر آپ کو کسی دوسری زبان میں معاونت کی ضرورت ہے یا آپ کو کسی اور فارمیٹ کی ضرورت ہے جیسے بڑے پرنٹ کی، تو براہِ کرم 1-877-482-9045 پر یا اپنے ہیلتھ پلان ID کارڈ پر دئے گئے ممبر نمبر پر کال کریں، TTY / RTT 711 ۔ آپ کے لئے ترجمہ خدمات اور ترجمان بغیر کسی معاوضہ کے دستیاب ہیں۔

Deutsch

Wenn Sie Hilfe in einer anderen Sprache oder ein anderes Format benötigen, z. B. Großdruck, rufen Sie bitte 1-877-482-9045 oder die Telefonnummer für Mitglieder an, die auf Ihrer Versicherungskarte angegeben ist, TTY / RTT 711. Übersetzer- und Dolmetscherdienste stehen Ihnen kostenlos zur Verfügung.

日本語

他の言語でのお手伝いや他の形式（大きな文字など）が必要な場合は、1-877-482-9045 または医療保険プラン ID カードに記載されている電話番号（TTY／RTT は 711）にお電話ください。翻訳サービスと通訳は無料でご利用いただけます。

ភាសាែខ្មរ

ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសាផ្សេង ឬអ្នកត្រូវការជាទ្រង់ទ្រាយផ្សេង ដូចជាអក្សរពុម្ពធំៗ សូមហៅទូរស័ព្ទទៅលេខ 1-877-482-9045 ឬលេខសមាជិកនៅលើប័ណ្ណ ID គម្រោងសុខភាពរបស់អ្នក, TTY / RTT 711។ សេវាបកប្រែភាសា និងអ្នកបកប្រែផ្ទាល់មាត់ គឺអាចរកបានសម្រាប់អ្នកដោយឥតគិតថ្លៃ។

United Healthcare

Notice of non-discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

Email: UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call **toll-free 1-877-482-9045** or the toll-free number on your health plan ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 6 p.m., PT.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, D.C. 20201

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

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