Patient Name: _____

Subscriber ID: _____

Group/Policy #: _____

**AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION**

**This authorization must be written, dated and signed by the consumer or by a person authorized by law to give this authorization. File copy and facsimile transmission are considered equivalent to the original (unless applicable state law provides otherwise). If UnitedHealthcare seeks the authorization from an individual for a use or disclosure of PHI, UnitedHealthcare must provide the individual with a copy of the signed authorization.**

I authorize United Healthcare Insurance Company, and its subsidiaries/affiliates ("UnitedHealthcare"), to use or disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records, as described below. I understand these records may contain information created by other persons or entities, including health care providers as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services [Note: psychotherapy notes may be used/disclosed only pursuant to a separate authorization pertaining only to psychotherapy notes], reproductive health services, and treatment for sexually transmitted diseases.

1. Persons/entities authorized to receive the information:

2. Type of information UnitedHealthcare is authorized to use or disclose:

3. The information will be used or disclosed for the following purposes:

4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my enrollment in the health plan, eligibility to receive benefits, ability to obtain treatment, or ability to receive payment for treatment, unless allowed by law.

5. I understand that I may revoke this authorization at any time by notifying UnitedHealthcare in writing at United Healthcare Appeals, PO Box 659773, San Antonio, TX 78265-9773, except to the extent that:
   (a) We have taken action in reliance on this authorization; or
   (b) If authorization was obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

6. This authorization expires [on] [upon] _____[date] or is valid _____ [event].

7. UnitedHealthcare will not receive compensation from a third party for using or disclosing this information.

I understand that once health information about me has been disclosed by United Healthcare Insurance Company to a third party, the health information may no longer be protected by federal privacy laws.

| _____ | _____ |
|---|---|
| **Printed name of consumer or consumer's representative** | **Relationship to consumer and authority to act for consumer** |
| _____ | _____ |
| **Signature of consumer** | **Date** |

**Internal Use Only:**
Forward to NASC Duluth

Form: AUTH UNI 021403