Authorization for release of protected health information (ROI)

Optum [System Platform]

Optum uses this form to get your permission to disclose your personal health information, which is known as Protected Health Information (PHI) under the law. **By completing and signing this form, you agree that Optum and its related businesses may disclose information to the people or organizations you provide below.** By Optum's related businesses, we mean its subsidiaries and affiliates.

Please print legibly

1 Member information (please provide current information)

Last Name | First Name | MI

Mailing Street Address | Apt. #

City | State | ZIP

Member ID Number

Date of Birth (mm/dd/yyyy) | Phone Number with Area Code

2 People or Organizations who will receive this information

I agree that Optum and its related businesses may disclose my PHI to the people or organizations named below. I understand that health care providers, health plans, and others are required to protect my PHI under federal law. If a person or organization is not a health care provider, health plan, or another party required to protect my PHI, it could be discussed or released without my permission.

This form should not be used to request a copy of your records; please see Instructions for information to submit a Request for Records.

Person or Organization #1

Name | Phone Number with Area Code

Mailing Street Address | Apt. #

City | State | ZIP

Relationship to Member

Person or Organization #2

Name | Phone Number with Area Code

Mailing Street Address | Apt. #

City | State | ZIP

Relationship to Member

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 health information. This may include medical, pharmacy, dental, vision, mental health, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information. I also intend this disclosure to include all substance use disorder records (if any).

Description: _____

_____

_____

4 Purpose of disclosure

The purpose of this authorization is to disclose my health information held by Optum at my request. If there are other purposes or reasons for this authorization, **please provide them below.**

Purpose: _____

_____

_____

5 Expiration and revocation

This authorization will be active for **3 years** (36 months) from the date of my signature below ***or*** on the date I have indicated below ***or*** as required by law. If you are a resident of Maine, Maryland, Minnesota, or Montana the expiration date cannot exceed the following length of time:

- Maine: 30 months
- Maryland: 12 months
- Minnesota: 12 months
- Montana: 30 months

This authorization will expire on (insert date): _____.

I have the right to end this authorization at any time by notifying Optum in writing at the address listed below. I understand that ending this authorization will not affect Optum's disclosures or uses of PHI by Optum before receiving my notice.

6 Authorization and signature of individual or individual's legal representative

I have read and understand this Authorization for Release of Protected Health Information. **I understand that by signing this form I am voluntarily giving my permission for Optum to use and disclose my PHI to the people or organizations named in Section 2.** Optum will not deny treatment, payment, enrollment, or eligibility for health care benefits if I do not sign this authorization.

X _____ _____

Member Signature Date

Name and relationship if signing on behalf of a minor child:

_____

If on behalf of a minor child, we may require additional information.

If this authorization is signed on the member's behalf by someone other than the parent or guardian, as such their legal or court appointed representative, please **attach documentation of the legal authorization and complete the following**. This can include a power of attorney or a court order. **Do not** send your original legal documents. Only send a copy of these documents as we **do not** have the ability to return your original documents.

Legal Representative's Name Date

Mailing Street Address Apt. #

City State ZIP

Relationship to Member

Please mail the completed form to:
Optum
Attn: ROI Processing
PO BOX 1495
Shawnee Mission, KS 66222

or fax to **1-866-322-0051**

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

For Authorized Representatives Who Are Receiving Substance Use Disorder Information
This information may have been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2.

Optum

Instructions for Completing Authorization for Release of Information

1. Demographical Information	Fill in your name, date of birth, address information and your subscriber ID. This information is required for identification and authentication purposes.
2. People or Organizations who will receive this information	Write the name and address of the individual(s) that you authorize Optum to disclose information to regarding your care. *This form should not be used to request a copy of your records; it is intended to allow us to share protected health information (PHI) with the individual you have authorized. If you or your legal representative would like to request a copy of your records, please complete the "Request for Access to Protected Health Information" form, which can be obtained through the instructions below:* • *Go to https://individualrights.optum.com/. Navigate to Forms, select the type of healthcare information needed and submit an electronic request using the link under "Get it," or* • *Call customer service at the telephone number located on your health plan ID card and ask that we mail or email a "Request for Access to Protected Health Information" form to you. The form will provide further instructions for completion and where to send it to obtain your records.* *Please note: You must list someone other than yourself as an authorized individual. If you list yourself as the authorized individual, your form will be rejected.*
3. Description of Information to Use or Disclose	Leave this section blank if you would like all information to be disclosed to your representative. If you would not like all information to be disclosed to your representative please write on the line what information you would like disclosed.
4. Purpose of Disclosure	The purpose of this authorization is to disclose your health information held by Optum at your request. If there are other purposes or reasons for this authorization, please write the reason on the line provided.
5. Expiration and revocation	This authorization will be active for **3 years** (36 months) from the date of your signature in section 6 ***or*** on the date you have indicated in this section. If you are a resident of Maine, Maryland, Minnesota, or Montana the expiration date cannot exceed the following length of time: Maine: 30 months Maryland: 12 months Minnesota: 12 months Montana: 30 months
6. Authorization and signature of individual or individual's legal representative	Member must sign and date the form unless the form is accompanied by a Legal document that gives authority for someone to sign and date on member's behalf. Please do not send original legal document, only send a copy, as we are unable to return document.