



Patient name: _____
 MRN _____ DOB: ____ / ____ / ____
 Address: _____
 City: _____ State: _____
 Zip: _____ Phone #: (____) _____
 Email: _____

Authorization for disclosure of protected health information

Optum and its entities will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

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| <p>This authorizes the following Optum clinic(s)/affiliate(s):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>to disclose information as specified below for the following purpose(s):</p> <p><input type="checkbox"/> Personal <input type="checkbox"/> Legal <input type="checkbox"/> Insurance purposes</p> <p><input type="checkbox"/> Continued medical care</p> <p><input type="checkbox"/> Other _____</p> | <p>Optum may disclose this information to:</p> <p><input type="checkbox"/> Check if same as above (disclosure to patient)</p> <p>Recipient</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____</p> <p>Phone #: (____) _____ Fax #: (____) _____</p> <p>Email: _____</p> |
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Copies of records or medical record information within the following dates: _____ to _____

Medical office/Clinical records Hospital records All records for specified physician or facility/clinic

Records limited to a specific provider _____ or Department: _____

X-ray films X-ray digital images Laboratory results Billing/Claims information

Note: Hospital and medical office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.

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| <p>The actual treatment records from restricted or sensitive health information are specifically protected, and will not be disclosed unless you sign below.</p> | |
| <p>Mental/behavioral health records</p> <p>Alcohol/drug dependency treatment records</p> <p>HIV testing results/AIDS treatment</p> <p>Sexually transmitted disease (STD)</p> <p>Genetic testing/test results</p> | <p>- Signature: _____</p> <p>- Signature: _____</p> <p>- Signature: _____</p> <p>- Signature: _____</p> <p>- Signature: _____</p> |

Media type: Electronic Paper **Delivery preference:** Email/secure portal/encrypted US Mail Pick-up

Duration: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here ____ / ____ / ____ (date).

Revocation: Patient or Personal Representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

Re-disclosure: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before disclosing this information.

Fee disclaimer: Federal and state laws permit Optum to charge a reasonable fee for copying/releasing records. State regulated fees for labor and supplies may apply. You will be notified in advance regarding any fees and payment as required. A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

_____ Date _____ Signature _____ If not the patient, print your name and relationship. Verification of right to request, if not patient, e.g., legal documentation, required.

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| <p>Office use only: Date received: ____ / ____ / ____ Received by (Print name/Initial): _____ / ____</p> |
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