EXTERNAL PURPOSES ONLY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FROM:

Patient Name: _____

MRN: ___ /___ /___ DOB:___ /___ /___

Address: _____

City: _____

State: _____ Zip: _____

Phone: ( ) _____

Email: _____

Site/Group/Practice/Entity Name:

_____

Address: _____

City: _____

State: _____ Zip: _____

Phone: ( ) _____

Fax: ( ) _____

Email: _____

Covered Entity will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

ENTITY MAY DISCLOSE THIS INFORMATION TO:

This authorizes: _____

clinic(s)/affiliate(s):

_____

_____

_____

to request information as specified below for the following purpose(s):

❒ Continued medical care

❒ Insurance purposes

❒ Other _____

Site Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: ( ) _____

Fax: ( ) _____

Email: hiscorrespondencedept@optum.com

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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The actual treatment records from restricted or sensitive health information are specifically protected, and will not be disclosed unless you sign below.

Mental/behavioral Health records Signature: _____

Alcohol/drug dependency treatment records Signature: _____

HIV testing results/AIDS treatment Signature: _____

Sexually transmitted disease (STD) Signature: _____

Genetic testing/test results Signature: _____

Media type: ❒ Electronic ❒ Paper
Delivery preference: ❒ Email/secure portal/encrypted ❒ US Mail ❒ Pickup

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 the entity to charge a reasonable fee for copying/releasing records. State regulated fees for labor and supplies may apply. You should 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.

_____

Signature Date

_____

If not the patient, print your name and relationship. Verification of Right to Request, if not patient, e.g. legal documentation, required.

Office use only:

Date received: ___ /___ /___

Received by (Print name/Initial): _____