United Healthcare

Mail or fax the completed form to:
UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770
1-888-950-1170

Authorization to Share Personal Health Information

The purpose of this form is to give UnitedHealthcare Insurance Company (UHIC) permission to share your personal health information with the trusted person or an organization you name below. Please complete and sign the form. Your health benefits will not be affected if you do not sign this form.

Member Information (Required)

Full name _____

Address _____

City _____ State _____ ZIP _____

Member ID _____ Date of birth _____

Phone Number _____

Email Address (optional) _____

Who do you want to share this information with? (required)

Name/entity_____

Address _____

City _____ State _____ ZIP _____

☐ Check here is you want this person or organization to receive copies of letters we send to you.

Your permission (required)

Personal Health Information (PHI) is protected by the Health Insurance Portability and Accountability Act (HIPAA).

When you sign this form, you agree to the following: UnitedHealthcare Insurance Company (UHIC) and its related companies have permission to give my personal health information to the person or organization listed in the section above. Records may contain information on specific medical care or services I received. They may also contain information created by others. The information may include medical, claim or benefit records.

☐ Check here if you authorize the release and disclosure of claim sensitive record(s). A claim sensitive record may be a mental health, genetic testing, sexual or physical mental abuse, alcohol or substance abuse, or HIV/AIDS record.

Sign here Date _____

☐ Check here, and complete the Legal Representative Information section below if you are signing as a legal representative.

If the member can only sign with an "X," a witness will also need to sign the form. This witness can't be any person or organization who will get the member's personal health information.

Witness Sign here Date _____

Legal Representative Information

If the member can't sign this form, a legal representative may sign, complete and return this form for the member. Please include a copy of the legal representative's authority if it's not already on file with UnitedHealthcare. A legal representative is someone who has the legal right to sign for the member.

Full name _____

Address _____

City _____ State _____ ZIP _____

Phone number _____

How long does this permission last?

Your permission lasts as long as you're enrolled in the plan or until you end it, whichever happens first. To end your permission before then, send a written request to:

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

Please make sure your request is signed and dated and keep a copy for your records.

What happens to my health information after UnitedHealthcare shares it?

We can't control what happens to your information after we share it with the person or organization you name on this form. At that point, HIPAA or federal privacy laws may not protect your information. It could be shared with others.

Questions?

Call member services toll-free at **1-855-409-0219**, TTY **711**, 8 a.m.-8 p.m. local time, Monday - Friday.