Optum

Authorization to use and disclose Protected Health Information (PHI)

Optum®, on behalf of itself and affiliated companies, cannot disclose PHI without consent from the patient / member that the information is about. We use this form to obtain your written consent to disclose your protected health information to someone designated by you. This request does not allow your designated person to make any of your treatment decisions or direct care decisions. Use this form to consent to the release of verbal or written PHI, including your profile or prescription records, to your designated person, named in Section 2 below. When filling out this form, provide your most current information.

1. Patient/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. Designated person information

I authorize Optum to use and disclose my PHI to the person(s) or organization(s) designated below. I understand that there are certain parties that must protect the privacy of my PHI. These are health care providers and other parties who are required to do so under federal or related state laws. If my designated person is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by them without my permission.

Authorized person #1

Name	Phone number with area code	
Mailing street address		Apt. #
City	State	ZIP
Relationship to patient		

Authorized person #2

Name	Phone number with area code	
Mailing street address		Apt. #
City	State	ZIP
Relationship to patient		

3. Description and purpose of disclosure

Select the company that applies to your request*:

☐ All Optum entities and affiliates listed below
☐ Optum® Specialty Pharmacy
☐ Optum® Infusion Pharmacy
☐ Optum® Home Delivery
☐ Optum Rx® retail / pharmacy benefits

* If a selection is not made, this authorization will apply to all Optum businesses with which you have an account.

The following items require special consent by law.

Check the boxes below to indicate your intent to include:

☐ Alcohol or substance abuse
☐ Genetic information
☐ HIV / AIDS
☐ Mental or behavioral health
☐ Reproductive health

Please describe the information covered by this consent, and the purpose of the disclosure. I understand that by leaving this section blank, I am authorizing the disclosure of all of my PHI, including my patient profile and pharmaceutical records, to my authorized representative(s).

Description:

4. Expiration and revocation

I understand that this consent will expire thirty six (36) months from the date of my signature as noted below unless I revoke in writing, request a different date below, or am a resident of a state that requires a shorter time frame.

If I wish for my consent to expire on a different date, noted here: _____

For those residing in states below, the expiration date cannot exceed:

12 months: MD, MN 24 months: MT, VA, Puerto Rico 30 months: ME

5. Signature

A. Authorized person designated by member or patient:

I have read and understand the above information. I acknowledge that by signing this form, I understand that my decision of whether or not to sign this form will not affect my eligibility for treatment or payment and am voluntarily giving consent to Optum and its affiliates to use and/or disclose my PHI to the person(s) or organization(s) designated in Section 2.

Signature of member or patient: _____ Date: _____

B. Personal representatives who are legally appointed:

I have read and understand the request and acknowledge that by signing this form I have the legal authority to act on behalf of the member or patient, and am attaching the appropriate documentation to this request.

Signature of Personal Representative: _____ Date: _____

6. Return the completed form

Mail: **Optum**
Mail Stop: KS015-1000
6860 West 115th Street
Overland Park, KS 66211-2457

Fax: **1-866-889-2116**

Please keep a copy of this form for your records.

Optum