UnitedHealthcare®

Authorization to Share Personal Information

Send the completed form to: UnitedHealthcare, P.O. Box 29450, Hot Springs, AR 71903-9450
Or fax to: 1-866-994-9659

You can give permission to UnitedHealthcare® to share your personal health information with a person or organization. To do so, please complete and sign this form.

How long does this permission last?
In most cases, permission to share your personal health information ends:

- Your last day as a plan member, or
- When you write to us and tell us to end it.

When I give permission to someone with this form, what can that person do for me?
The person can:

- Get plan information, such as: premium amounts and how you pay, what the plan covers, and claims we get from doctors, hospitals or pharmacies for your care.
- Correct your phone number and mailing address, if we have the wrong information.
- Stop some types of payment, such as: automatic monthly payments from your bank, credit card, or Social Security or Railroad Retirement Board check.

The person can't:

- Change your plan.
- Make an appeal for you.
- Decide what kind of care you get.
- Change your physical address, if you've moved. You, your Power of Attorney, guardian or conservator must give us the change.

Once I give permission, can I change my mind and "take it back"?
You can tell us to stop sharing your information in the future. However, it's not possible to "take back" information we've already shared.

How do I end permission to share my personal health information?
You will need to send us a letter. Be sure to sign and date it. You can mail or fax the letter. Please keep a copy for your records.

What happens to my health information after UnitedHealthcare shares it?
The Health Insurance Portability and Accountability Act (HIPPA) protects your health information. But, 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.

What if I refuse to sign this form?
You may refuse to sign. Your health benefits will not be affected.

Member Information (This section must be completed)

Member ID number	Member date of birth MM / DD / YYYY

Member first name	Middle initial

Member last name

Member permanent address

City	State	ZIP code

If your permanent address is outside of the plan's service area, you will lose your plan.

Date at permanent address MM / DD / YYYY

Daytime telephone number – –	Evening telephone number – –

Email address (optional)*

*If you give an email address, we'll send you plan updates from time to time. You can tell us at any time to stop sending these emails.

Who Do You Want to Share Your Information With? (This section must be completed)

Name

Address (optional)

City	State	ZIP code

Your Permission (This section must be completed)

When you sign this form, you agree to the following: UnitedHealthcare Insurance Company (UHIC) and its related companies may give my personal health information to the person or organization I name on this form. My records may have information about specific medical care or services I got. They may also have information other people created. The information may include medical, claim or benefit records.

Sign Here Date MM / DD / YYYY

☐ Check here, and complete the Legal Representative Information section 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 receiving the member's personal health information.

Witness Sign Here Date MM / DD / YYYY

Legal Representative Information

If the member can't sign this form, a legal representative may sign, complete and return this form for the member. A legal representative is someone who has the legal right to sign for the member. **Please attach proof that you are the member's legal representative (for example, Power of Attorney). We can't accept this form without it.**

First name	Middle initial
Last name	
Address	

City	State	ZIP code

Telephone number

___ - ___ - ____

Where to send this form

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Questions?

Call Customer Service at the toll-free number on the back of your member ID card.