



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

_____	_____	_____
Individual's Full Name	Date of Birth	Member or Subscriber ID #
_____	_____	
Individual's Street Address	City/State/Zip Code	

I UNDERSTAND AND AGREE THAT:

- this authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying Optum in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

WHO MAY RECEIVE AND DISCLOSE MY INFORMATION:

I authorize WellMed and its affiliates to disclose my individually identifiable health information to the following person(s) or organization(s):

(Full Name of Person(s) or Organization(s))

(Full Address of Person(s) or Organization(s))

TYPE OF INFORMATION TO BE DISCLOSED:

I authorize disclosure of all my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
OR

I authorize only the disclosure of the following information:

(Type of Information)

PURPOSE OF DISCLOSURE:

My health information is being disclosed at my request or at the request of my personal representative; **OR**

My health information is being disclosed for the following purpose:

(Explain Purpose)

Signature of Individual

Date

Witness Signature (For Illinois Residents Only)

Date

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

Signature of Individual's Representative

Date

Personal Representative's:

Name

Phone Number

Street Address

City/State/Zip Code

(For California and Georgia residents only) I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS