

# Authorization for release of health information

## Rocky Mountain Health Plans

Member's full name:

Date of birth:

Member or subscriber ID#:

Member'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 redisclosure 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 1 year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare 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 UnitedHealthcare and its affiliates to receive from or 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):

#### Full name of person(s) or organization(s):

Full address of person(s) or organization(s):

#### Full name of person(s) or organization(s):

Full address of 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** (choose 1 option)

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** (choose 1)

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 member:	Date:
Witness signature <b>(for Illinois residents only)</b> :	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 and complete the following:

**Guardian or representative:**

Name:	Phone number:	
Address:		
City:	State:	ZIP code:
Signature of guardian or representative:	Date:	

**(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 form for your records and return it to:**

Rocky Mountain Health Plans  
2775 Crossroads Blvd.  
Grand Junction, CO 81506

