AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

OptumRx, on behalf of itself and affiliated companies, uses this form to get your permission to use and/or disclose your protected health information (PHI) to your authorized representative. This authorization does not allow your authorized representative to make any of your treatment decisions or direct care decisions. If you want help with your health care and treatment decisions, you must get additional legal documentation.

Use this form to request authorization for the release of PHI, including patient profile or prescription records, to your authorized representative(s) named in Section 2 below. When filling out this form, provide your most current information.

1 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 Authorized representative's information

I authorize OptumRx to use and disclose my PHI to the person(s) or organization(s) named 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 authorized representative is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by my authorized representative without my permission.

Authorized representative #1

Name | Phone Number with Area Code

Mailing Street Address | Apt. #

City | State | ZIP

Relationship to Member

Authorized representative #2

Name | Phone Number with Area Code

Mailing Street Address | Apt. #

City | State | ZIP

Relationship to Member

3 Description of information to use or disclose

Please describe the information covered by this authorization.

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 Purpose of disclosure

The purpose of this authorization is to assist me in receiving my health plan benefits and make payments for my health plan benefits. If there are other purposes or reasons for this authorization, they are provided below.

Purpose:

5 Expiration and revocation

I understand that I have the right to end this authorization at any time. I understand that if I do not wish the person(s) named in Section 2 to remain my authorized representative, I must cancel this authorization **in writing** and send such notice to the address listed below. I understand that a cancellation of this authorization has no effect on disclosures or uses of PHI by OptumRx before receiving my cancellation notice.

I understand that this authorization will expire on (insert date):_____ . If I do not provide an expiration date, I am aware that this authorization is valid for sixty (60) months from the date of my signature as noted below.

6 Authorization and signature of individual or individual's LEGAL representative

I have read and understand the content of this Authorization to Use and Disclose PHI. This authorization correctly describes my request of OptumRx. I understand that by signing this form, I am voluntarily giving my permission for OptumRx to use and/or disclose my PHI to the person(s) named in Section 2. Any services otherwise provided to me by OptumRx will not be affected by my decision to provide this authorization. I may refuse to sign, and OptumRx will not condition my treatment, payment, enrollment or eligibility for benefits on my decision to sign or not sign this authorization.

X _____ _____
Member Signature Date

X _____ _____
Witness Signature Date
(A witness signature is only needed if the member is unable to sign or the witness is an interpreter)

If this authorization is signed on the member's behalf by his/her legal representative, please **attach documentation of legal representative designation and complete the following:**

Legal Representative's Name		Date	
Mailing Street Address			Apt. #
City	State	ZIP	
Relationship to Member			

7 Please mail the completed form to: Irving Pharmacy 118 Wyckoff Ave Brooklyn New York 11237 or Fax to 718 484 8508.

Please keep a copy of this form for your records. You also have the right to receive a copy of this authorization.

Print form