WellMed® | Optum

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN MEDICAL RECORDS

PATIENT IDENTIFICATION:

Patient's full name:_____ Phone:_____

Full address:_____

Other name(s) used:_____ Date of birth:_____

Both sections must be completed

DISCLOSE/COPY MY MEDICAL RECORDS FROM:

Person/organization name:_____

Full address:_____

_____

Phone:_____ Fax:_____

SEND MY MEDICAL RECORDS TO:

Person/organization name: _____

Full address:_____

_____

Phone: _____ Fax:_____

Email (for delivery by secure email):_____

REASON FOR DISCLOSURE:

- ☐ Treatment/continuing care
- ☐ Personal use
- ☐ Billing or claims
- ☐ Legal purposes
- ☐ Insurance / disability
- ☐ Email
- ☐ Other:_____

FORMAT OF DELIVERY:

(Honored when possible.)

- ☐ Mail – Paper
- ☐ Mail – CD / DVD
- ☐ Fax
- ☐ Email
- ☐ Other:_____

DISCLOSE THE FOLLOWING PHI IN MY MEDICAL RECORDS: Mark all that apply.

Date range, if applicable:_____

- ☐ All health information
- ☐ Clinician orders
- ☐ Clinician notes
- ☐ Billing information
- ☐ Procedure reports
- ☐ Lab reports
- ☐ Radiology __Reports __Images
- ☐ Consultation reports
- ☐ Other_____

Your initials are required if you **DO NOT** want to release any of the following sensitive information:

____ Mental health records (excluding psychotherapy notes)
____ Drug, alcohol, or substance abuse records
____ Genetic information (including genetic test results)
____ HIV/AIDS test results / treatment
____ Reproductive health

I freely authorize the named person/organization to release my medical records to the named person/organization with the understanding that:

1. A photocopy or fax of this authorization is as valid as this original.
2. I may revoke this authorization at any time in writing, except where information has already been released.
3. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
4. I do not need to sign this form in order to ensure healthcare treatment, payment, enrollment or eligibility.

_____ _____

Signature of patient or parent / legal guardian | Date

_____ _____

Relationship to patient[1] | Expiration date of authorization[2]

1. Please note: If you are a guardian or court-appointed representative, you must attach a copy of your legal authorization to represent the patient, except in the case of the parent of a minor patient. 2. Unless noted, authorization expires 1 year from date of signature above.