

Authorization for Release of Health Information

Please keep a copy of this form for your records.

Member's personal information		
Full Name		
Member/Subscriber ID	Date of Birth	
Address		
	StateZIP Code	
providers. It may be these type o Medical records o Pharmacy o Dental records o Vision care o Mental health I may not be denied treatment of form. I may not be denied eligible My health information may be shealth plan or provider, the information will expire one time. To do so, I must notify Unhave an effect on any actions possible.	 Substance abuse care HIV/AIDS Psychotherapy Reproductive care Communicable disease propayment for health care if I do not sign this politity for health care if I do not sign this form. Shared by the recipient. If the recipient is not a permation may not be protected by the federal rules year from the date I sign it. I may revoke it at any itedHealthcare in writing. The revocation will not rior to the date it is processed. 	
Full name of person(s) or organizat	ion(s)	
Full name of person(s) or organizat	ion(s)	



Type of information to be sl	hared (check one of	f the boxes)		
	ıll my health informat	tion. This includes these types of		
information:				
Medical records		ubstance abuse care		
Pharmacy Dental records		IV/AIDS		
Dental recordsVision care		sychotherapy		
Wision care Mental health		eproductive care ommunicable disease		
■ I authorize only the disclosure of the fo				
T authorize only the disclo	sare or the following	j illioittiation.		
Purpose of disclosure (checonomy) ☐ My health information is bordered and the composition of the composition is bordered and the composition is bordered.	peing shared at my re	equest or at the request of my		
Signature Signature of Member		 Date		
Witness Signature (For resid	onte of Illinois only)	 Date		
Witness Signature (For reside	ants of minois only)	Date		
Personal representative If you are a guardian or court authorization to represent the		ntative, you must attach a copy of you	ır legal	
Personal Representative's Na	ame			
Address				
City	State	ZIP Code		
Phone Number				
Signature of Member's Repre	esentative	 Date		

(For residents of California and Georgia only) I understand that I may see and copy the above-mentioned information if I ask for it. I may get a copy of this form after I sign it.