UnitedHealthcare®
A UnitedHealth Group Company

M.D.IPA℠ OPTIMUM CHOICE® MAMSI® LIFE AND HEALTH INSURANCE COMPANY

# Authorization for Release of Health Information

## (Expiration Following Disenrollment/Enrollee Initiated)

MD-Individual Practice Association, Inc., MAMSI Life and Health Insurance Company, and Optimum Choice, Inc. ("Health Plan") are able to release your health information if an Authorization for Release of Health Information (hereinafter referred to as "Release") is on file.

This Release will allow another person or an organization (including a spouse, family member, friend or employer benefit administrator, hereinafter referred to as "Recipient") to have access to your health information. Your health information is any information we maintain in the records of the Health Plan that relates to your past, present or future physical or mental health or medical condition, including any personal financial information.

A separate Release must be completed for each Recipient. If you are the subscriber to the policy (identified on your health plan identification card by the suffix "*01" in your member number), you may authorize a Release on behalf of each minor child/dependent on your policy. However, each member over the age of 18 years must complete and authorize his or her own Release.

1. **Enrollee identification and contact information**

The enrollee identified in this section is the person whose health information may be disclosed pursuant to this Release. Please provide your name and personal identification information, along with additional contact information in case we have any questions concerning this Release. If this Release is being completed for a minor child/dependent, please provide the name and personal identification information for the minor child/dependent.

Name: ________________________________________________
Health Plan Identification Number : ______________________________
Social Security Number: ____________________________________
Daytime Telephone Number : ________________________________
Evening Telephone Number : ________________________________
E-mail address : ________________________________________

**2. Recipient Information**

Health Plan may release your health information to the following individual or organization:

2.01 Name: ________________________________________________
2.02 Address : _____________________________________________
2.03 Date of Birth (required, if Recipient is an individual) ________________
2.04 Health Plan Identification Number, if applicable: _________________

**3. Release limitations**

Health Plan may release your health information subject to the following limitations (check all that apply):

3.01 _____ Complete authority
(may receive and make changes to all health information on file and may represent me in all matters with respect to my health insurance).
3.02 _____ Inquiry only
(may receive all health information on file, but may not make changes to health information on file).
3.03 _____ Primary Care Physician ("PCP") updates only.

3.04 _____ Other limited access (please specify): ______________________________

4. **Expiration and revocation**

This Release will expire one year after termination of your health insurance coverage under your current Health Plan, or, if the enrollee is a minor, on such enrollee's 18th birthday. You may revoke this authorization at any time by notifying the Health Plan in writing, and such revocation will take effect once it is received by the Health Plan and will not affect any use or disclosure of information before the revocation is received by the Health Plan.

NOTE: If you live in the state of Pennsylvania, this Release shall expire on the second anniversary of the date of this Release as set forth below.

If you live in the state of Maryland, this Release shall expire on the first anniversary of the date of this Release as set forth below.

5. **Personal Representative** (If the person identified in Section 1 is signing this form, skip this section and go to Section 6.)

This Release may be completed and signed on behalf of any enrollee by the enrollee's Personal Representative. A Personal Representative is a person who has legal authority to act in health care matters on your behalf, including a person who has been given a power of attorney, or a court-appointed guardian. **Please attach the legal document** that gives you the authority to act on behalf of the enrollee.

Name of Personal Representative: ____________________________________________________
Relationship of Personal Representative to Enrollee or Subscriber: __________________________
Personal Representative Telephone Number:

Daytime Telephone Number: _________________________________
Evening Telephone Number: _________________________________

6. **Procedure to file or revoke this form**

After completing and signing this form, please return it to the address listed below or fax the form to 301-360-8917

**Group Services Department**
**P.O. Box 931**
**Frederick, MD 21705**

For additional information, call Member Services 301-360-8115 or 1-800-709-7604.

To revoke this form, you may submit your request by fax or by mail to the address listed above. Please include your name, and health plan identification number, member number and, if applicable, identify your status as a Personal Representative (see paragraph 5 above) in your correspondence, as well as the name of the person who should no longer have access to your health information.

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By signing where indicated below, you acknowledge your understanding that (i) this authorization is voluntary, (ii) you may refuse to sign this form, and (iii) the released health information may be re-disclosed by the Recipient and may no longer be protected by federal privacy regulations if the Recipient is not a health plan, health care practitioner or other business covered by applicable privacy laws or regulations. You are entitled to a copy of this signed form.

____________________________________________ Date: ________________________________

**Signature of Enrollee**
An enrollee's or subscriber's Personal Representative
Or a subscriber acting on behalf of a non-adult enrollee

___________________________________________

**Printed name of Enrollee**
An enrollee's or subscriber's Personal Representative
or a subscriber acting on behalf of a non-adult enrollee