OPTUMRx®

Do not write in this area

Authorization Form

OptumRx, on behalf of itself and affiliated companies, uses this form to get your permission to discuss and/or release your personal health information ("PHI") to a person who is your Authorized Representative. Your approval on this form limits the use of your information for that purpose only. 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. If you have questions, contact your attorney.

Section A: Patient or Member Information and Authorized Use and/or Disclosure

By *signing this form in* ***Section E*** *on the next page*, I understand and agree that OptumRx, on behalf of itself and affiliated companies, may release my PHI, including patient profile or pharmaceutical records, to my Authorized Representative(s) named in Section B below.

Member's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Member ID #: _____

Section B: Authorized Representative's Information

I authorize you to discuss and give out my PHI to the person(s) named below. I understand that it is for the purpose of helping me receive my health plan benefits or for payment of my health plan benefits. 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. I understand and agree that my authorization is voluntary.

Authorized Representative #1

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Relationship to Member: _____

Authorized Representative #2

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Relationship to Member: _____

Section C: Limitations on Disclosure

I understand that by leaving this section blank, I am allowing all of my PHI to be known by my Authorized Representative. *Otherwise*, please list limitations on disclosures below:

Limitations: _____

Section D: 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 B to remain my Authorized Representative, I must cancel this authorization **in writing** and send such notice to the address listed below. I understand that if you have already released any of my PHI before you receive my cancellation notice, my notice cannot cancel out any action you have already taken. I understand that this authorization will expire on (insert date): _____

Section E: Signature of Individual or Individual's Legal Representative

I have read and understand the content of this Authorized Representative Form. This authorization correctly describes my request of OptumRx. I understand that, by signing this form, I am giving my permission for OptumRx to use and/or give out my PHI to the person(s) named in Section B.

Member's Signature: _____ Date: _____

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 Form 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: _____

Address: _____ City: _____ State: ___ Zip: _____

Relationship to Member: _____

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

PLEASE RETURN THIS SIGNED AUTHORIZATION FORM BY MAIL OR FAX TO:

OptumRx
ATTN: A&G Correspondence Team
3515 Harbor Boulevard, CA106-0245
Costa Mesa, CA 92626

FAX: 714.825.6989