ProHEALTH℠ Care
Part of OptumCare™

PATIENT AUTHORIZATION FOR OBTAINING MEDICAL INFORMATION

Patient's Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Phone Number: _____
(Month/Day/Year)

Address: _____
(Street) (City/State) (Zip Code)

Please request/check all that apply:

I authorize_____ to disclose the medical information
(Name and Address)
requested below:

__Complete Medical Records: _____

_____
(Name and Address of Physician/Hospital) (Date(s))

__Specify (i.e. Lab tests, X-rays) _____
(Date(s))

Please Mail To:

Name of Physician:_____

Address:_____

Or Fax To: _____

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatrics records and or HIV-related information (indicating that I have had an HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the release of HIV-related information, the recipient(s) is prohibited from redisclosing any HIV-related information without my authorization unless permitted to do so under federal or state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be discclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Patient Signature:_____Date:_____

Personal Representative Signature:_____PrintName:_____
(only necessary in cases where patient is a minor or incompetent)

Authority:_____ Phone Number:_____

Address: _____ Date:_____