Optum

Nevada Care Delivery Organizations

Optum Care HIPAA authorization to use and disclose Protected Health Information (PHI)

Please note that there may be a charge for providing copies of your medical records as allowed by federal & state law

Optum Care Delivery Organizations (Optum CDOs) cannot disclose patient PHI without a valid authorization from the patient (or patient's representative). We use this form to obtain your written authorization to disclose your PHI to someone designated by you. This request does not allow your designated person to make any of your treatment decisions or direct care decisions. Use Section 2 of this form to authorize a designated person to receive verbal or written PHI on your behalf. When filling out this form, provide your most current information. Failure to fill out this form completely may cause delay in acting on your authorization.

Section 1. Patient information: Please provide current information.

Last name:	First name:	Middle initial:	Date of birth:
Mailing street address:			Apt.#:
City:	State:	Zip code:	Medical record #:
Phone number:	Email address:		

Section 2. Designation person: Who is receiving your records?

I authorize Optum Care to disclose my PHI to the person(s) or organization(s) designated below. 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 designated person is not a health care provider or another party required to protect my PHI, my PHI will no longer be protected by HIPAA, and it could be discussed and/or released by them without my permission. Send my medical records to:		
Name:		Relationship to patient:
Mailing street address:		Apt.#:
City:	State:	Zip code:
Phone number:	Fax number:	
Email address:		

Section 3. Description of PHI: What types of information do you want Optum Care to release?

At my request, I authorize the use and/or release of my records as indicated below to the person or entity listed in Section 2 above. **Check the boxes below to indicate date(s) of service and types of records to be released.**			
☐ Release my records these date(s) of service: from: _____to _____			☐ Release my records from the last ___ years
☐ Physician notes	☐ Physician's order	☐ Consultation reports	☐ Specialty diagnostic test results
☐ Lab reports	☐ X-ray reports	☐ Immunization records	☐ Billing records
☐ All medical records	☐ Other (be specific)		
The following items require special authorization by law. Check the boxes below to indicate your intent to include:			
☐ Alcohol, drug or substance abuse	☐ Genetic information	☐ Reproductive health	☐ HIV/AIDS
☐ Mental or behavorial health	☐ Other:		

Section 4. Purpose of disclosure: Check all that apply.

☐ Continuing care	☐ Referral to a specialist	☐ Change of doctor/provider	☐ Personal
☐ Insurance	☐ Work compensation	☐ Disability determination	☐ Legal
☐ "At my request"	☐ Other		

Section 5. Format and delivery method: Send my records to the individual/entity listed in Section 2. Check one option.

☐ Send paper copies by mail	☐ Fax	☐ Secure email (provide email)	☐ Pick up in person
☐ Other (specify other format and delivery method)			

Section 6. Expiration and revocation:

I understand that this authorization will expire twelve (12) months from the date of my signature as noted below unless I either: (1) revoke in writing. To revoke this authorization, I must do so in writing and present my written revocation to my Optum Care provider or by mailing to the address listed in Section 8 of this form. I understand that the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed by my Optum Care provider, (2) request a different date as noted below, or (3) I am a resident of a state that requires a shorter timeframe. I wish to request my authorization to expire on the date noted here _____.

12 months: MD, MN	24 months: MT, VA, Puerto Rico	30 months: ME

Section 7. Signature:

A. Authorized person designated by member or patient
I have read and understand the above information. I acknowledge that by signing this form, I understand that my decision of whether or not to sign this form will not affect my eligibility for treatment or payment and I am voluntarily authorizing Optum and its affiliates to use and/or disclose my PHI to the person(s) or organizations(s) designated in Section 2 above.

Patient signature:	**Date:**

B. Personal representatives who are legally appointed:
I have read and understand the request and acknowledge that by signing this form I have the legal authority to act on behalf of the patient, and am attaching the appropriate legal documentation to this request.

Signature of personal representative:	**Date:**

Section 8. Return the completed form to:

Mailing address: Optum Health Information Management P.O. Box 15645 Las Vegas, NV 89114-5645	**Fax:** 307-222-4187

Please keep a copy of this form for your records.

Office use only:

Date received: _____

Received by (Print name/initial: _____

Site ID/ticket: _____ Date completed: _____

☐ Faxed ☐ Mailed ☐ Emailed ☐ Picked up ☐ Other (e.g., patient portal) _____

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