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HIPAA Authorization For Release Of Information

Use This Form To Allow UHA To Give Out Your Personal Health Information

Please keep a copy for your records

1. **Member Name** _____ **Phone** _____

   Address _____ **Member Number** _____

2. **List the personal health information you want UHA to give out**
   - For example: "The claims information related to my hip surgery in January 2017," or "All my health information in 2017," or "All the records related to my heart problems"
   - Use a separate form for release of psychotherapy notes
   - You may also exclude some health information
     For example: "all my health information except mental health records" or "all my medical records except x-ray films"

   _____

   _____

   ☐ Please check here if you authorize UHA to give out information related to **all** of the following, should it be contained within your medical record or select the specific health information authorized by checking the box(es) below:

   ☐ HIV, AIDS, or AIDS-related complex diagnosis or treatment ☐ mental health counseling, diagnosis, or treatment

   ☐ alcohol or drug use, diagnosis, or treatment

3. **Name and address of the person or organization (recipient) to which UHA should give your personal health information**
   (For example: "My wife, Jane Doe" or "My grandson, John Doe" and the address)
   Name: _____ Address: _____

4. **Reason for the disclosure (**For example: "To answer questions about my claims" or "at the organization's request" or "for legal purposes")

   _____

5. **Right to take back ("revoke")**
   I may revoke this authorization at any time by giving written notice to UHA. I understand my revocation will NOT affect any disclosures that occurred before UHA received notice of my written revocation and there may be other legal restrictions on my ability to revoke this authorization.

   Date authorization expires (check one):

   ☐ Please revoke this authorization on the following date: __ __ / __ __ / __ __ __ __ (mm/dd/yyyy)

   ☐ Please revoke this authorization when the following event occurs: _____
   (For example: "When I terminate my UHA membership")

   ☐ No expiration (I will notify UHA in writing via mail or fax to: UHA Customer Services, at the address or fax number listed above)
   To revoke this authorization, I will write a letter including the following:
   - My name, address, and member number
   - The names of the person or organization I no longer wish to receive my personal health information
   - My signature

   If a box above is not checked, this authorization will expire one year from the date of the signature below.

6. **I, (print name) _____, authorize UHA to give out the protected health information** described above to the persons or organizations I named on this form. This authorization is voluntary. I understand that UHA will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed by law. I understand my protected health information may be re-disclosed by the recipient without my permission and may no longer be protected by law.

   Sign Your Name _____ Date _____

   If you are not the UHA member listed above you are signing as a personal representative. Please provide the following:
   - Attach the appropriate documentation (for example, Medical Power of Attorney, or court order)
   - Your phone number:_____