OPTUM Care™
Medical Group

## Disclosure of Protected Health Information and Notice of Privacy Practices Form

Name: _____ Date of Birth: _____ Today's Date: _____

**Communication of Information:**

**Please indicate your preference for how you would like us to contact you:**

( ) _____**Primary Phone Number**
❒ **Do** ❒ **Do Not** Leave detailed messages on my primary phone number

( ) _____**Secondary Phone Number**
❒ **Do** ❒ **Do Not** Leave detailed messages on my secondary phone number

**Authorization to Share Protected Health Care Information:**
**Your authorization will allow us to share your medical information to those identified family members, caregivers or others that are involved in your care.**

1. Extent of authorization
   a. ❒ I authorize the release of my complete health record

   b. ❒ I do not wish to release my health records

   c. ❒ I authorize the release of my records with the exception of the following information:
      - ❒ Mental health records
      - ❒ Communicable diseases (including HIV and AIDS)
      - ❒ Alcohol/drug abuse treatment
      - ❒ Other (please specify) _____

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**Disclosure of Protected Health Information and Notice of Privacy Practices Form (Continued)**

Name: _____ Date of Birth: _____ Today's Date: _____

2. Authorization

I authorize OptumCare Medical Group to use and disclose the protected information described below to:

Name: _____ Relationship: _____ D.O.B: _____ All info: ❒ Restricted info: ❒

Name: _____ Relationship: _____ D.O.B: _____ All info: ❒ Restricted info: ❒

Name: _____ Relationship: _____ D.O.B: _____ All info: ❒ Restricted info: ❒

3. Effective period

This authorization for release of information covers the period of health care from:

a. ❒ All past, present, and future periods

OR

b. ❒ _____ to _____

4. This medical information may be used for 1) medical treatment 2) billing purposes 3) other purposes I choose by those who have permission.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that if I cancel this authorization, it will not be effective 1) for those individuals who have already received information based on the previous authorization, 2) if my authorization was obtained for the purpose of obtaining insurance coverage, the insurer has a legal right to information related to claims.

6. I understand that once the information is disclosed to the authorized person, the medical group can no longer protect the information by federal or state law.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be affected by this authorization.

_____

(Signature of patient or personal representative)

_____

(Printed name of patient or personal representative and his or her relationship to patient)

_____

(Date)

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**OFFICE USE ONLY:**

**Entered into NextGen: Date: _____ Employee Signature: _____**