



Optum Behavioral Care:
Authorization for Release of Protected Health Information (“PHI”)

Optum Behavioral Care (“OBC”), and affiliated companies, will use this form to obtain your written authorization to disclose your PHI to the recipient of your choice (named in **Section 2** below). This request does not allow the recipient to make any of your treatment or direct care decisions. When filling out this form, please provide your most current information.

Please return this completed form to:

Mail: OBC Medical Records Department
 Attn: OBC Medical Records Coordinator
 PO Box 15006, Minneapolis, MN 55415-0006
 Phone: 877-204-2110
 Email: obcmedicalrecords@optum.com
 Fax: (866) 287-1210

1) Patient Information (please provide current information)

Last Name	First Name	Middle Initial
Mailing Street Address		Apt. #
City	State	Zip
Date of Birth (mm / dd / yyyy)	Phone Number with Area Code	

2) Individual or Organization Authorized to Receive Information

I authorize **Optum Behavioral Care (“OBC”)** to disclose my PHI to the individual or organization 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 individual is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by them without my permission.

Individual/Organization Name	Relationship to Patient	
Mailing Street Address	Unit/Suite #	
City	State	Zip
Phone Number with Area Code	Fax Number with Area Code	

3) Purpose and Delivery Method of Disclosure

<p>I authorize the above-mentioned facility to release my information for the following reason(s):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Coordination of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use <input type="checkbox"/> Other _____ 	<p>I authorize the above-mentioned facility to release my information via the following delivery method (please select <u>one</u>):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Verbal Disclosure ONLY (does not permit release of physical records) <input type="checkbox"/> Pick-up In Person <input type="checkbox"/> USPS Mail <input type="checkbox"/> Fax <input type="checkbox"/> Secure Email (provide email address below) <p style="margin-left: 40px;">Email Address: _____</p>
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4) Description of Information to be Disclosed

I authorize the following records to be disclosed:

ALL Mental/Behavioral Health Records

If not **ALL**, please select one (or more) of the following record types:

- | | |
|--|---|
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Medications/Dosing |
| <input type="checkbox"/> Assessments | <input type="checkbox"/> Provider Orders |
| <input type="checkbox"/> Billing Record | <input type="checkbox"/> Toxicology Results |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lab Results | |

The following items require special consent by law.

Check the boxes below to indicate your intent to include:

- | |
|--|
| <input type="checkbox"/> Alcohol or Substance Use |
| <input type="checkbox"/> Genetic Information |
| <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Reproductive Health Care Services |
| <input type="checkbox"/> Psychotherapy Notes |

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Please indicate in the space below the date(s) of service, for the above selected records, that you would like released

(If this section is left blank, all dates of service for the above selected records will be included):

5) Expiration and Revocation

I understand that this authorization will expire thirty-six (36) months from the date of my signature as noted below unless I revoke in writing, request a different date, or am a resident of a state that requires a shorter timeframe.

I wish for my authorization to expire on a different date, noted here: _____

For those residing in the states below, the expiration date cannot exceed:

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

I further understand that I may revoke this authorization at any time by notifying, in writing, the facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

6) Signature(s)

A. 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 am voluntarily giving consent to above-mentioned facility to disclose my PHI to the individual or organization designated in **Section 2**.

Signature of Patient

Date

B. Personal or Legal Representative of Patient: 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 I am attaching the appropriate supporting documentation to this request.

Printed Name of Representative

Relationship to Patient

Signature of Representative

Date