OPTUM® | Maryland

Authorization for Release of Health Information

Full Name	**Date of Birth**	**Participant ID #**	
Street Address	**City**	**State**	**Zip Code**

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by others, including health care providers. It may include medical, pharmacy, dental, vision, mental health, substance use disorder, HIV/AIDS, psychotherapy, reproductive, genetic communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- The information I authorize to be disclosed may no longer be protected and could be re-disclosed by the recipient if the recipient is not subject to federal or state privacy laws; and
- This authorization will expire one year from the date I sign it. I may revoke this authorization at any time by notifying Optum in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed. If I have authorized the release of ONLY alcohol or substance use treatment records, I may also revoke this authorization verbally.

I authorize the Maryland Department of Health and its Administrative Services Organization vendor(s) (currently Optum) and its affiliates to disclose my individually identifiable health information to the following person(s) or organization(s) (*Note that authorization to Optum may transfer to a new ASO during a transition year unless a PBHS participant request otherwise):

_____

(Full name of individual(s), organization(s) or group(s) (e.g., all my past, present and future doctors)

_____

(Full address and phone number of person or persons)

Type of Information to be Disclosed (select one):

☐ I authorize disclosure of all my health information. This may include medical, pharmacy, dental, vision, mental health, substance use disorder, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and other health care program information. This information may include, for example, information relating to visits, admissions, treatment, payment, claims, case management and care coordination; **or**

☐ Limited information: Please specifically identify what type of information you want disclosed. If you are authorizing release of substance use disorder information, please be explicit and specify how much and what kind of information is to be disclosed.

____

(Please Describe)

Purpose of Disclosure (select one):

☐ My health information is being disclosed at my request or at the request of my personal representative; **or**

☐ My health information is being disclosed for the following purpose(s) only (examples include claims management or payment, eligibility and benefits, disability management):

____

(Explain Purpose)

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___________________________________ _______________

Signature of Individual Date

Please note: If you are a legal guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member and complete the following:

______________________________________ ____________________

Signature of Individual’s Representative Date

Personal Representative's:

_____

Name Phone Number Role/Relationship to Individual

_____ _____ _____ _____

Street Address City State Zip Code

(*For substance use disorder information only)* If I chose a group of persons to receive my information, I understand that I may ask for a list of those to whom a disclosure is made.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

Fax: **844-887-9875**

and/or

Mail:

Attn: Maryland Optum ROI Team

10175 Little Patuxent Parkway, Columbia, MD 21044