Revised 12-29-2005

PRI-SI-FO-09 AUTHORIZATION FROM INDIVIDUAL

Purpose: This form is used to confirm the direction of an individual that our Company use or disclose protected health information for a particular purpose**.** **PLEASE RETAIN A COPY FOR YOUR RECORDS**.

SECTION A: Psychotherapy Notes.

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information. A separate authorization will need to be submitted for the use or disclosure of other types of protected health information.

SECTION B: Information about the Individual granting the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section C below**.** I understand this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

ID or Policy No.: _____ Social Security Number: _____

SECTION C: Information being authorized for use or disclosure.

Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing to be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization):

_____

_____

_____

Entities Authorized **to Receive and Use**: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing our Company to disclose and/or let use the protected health information described above:

_____ _____

_____ _____

_____ _____

SECTION D: Expiration and Revocation.

Expiration: This authorization will expire (complete one):

☐ On ____/____/_____ (Specific Date)

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

_____

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: UnitedHealthcare **Student**Resources' Privacy Office

Telephone: 1-888-889-3822 or 1-469-229-6500 **Fax**: 1-469-229-6555

Address: P.O. Box 809025, Dallas, TX 75380-9025

SIGNATURE OF INDIVIDUAL OR INDIVIDUAL'S PERSONAL REPRESENTATIVE.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the Company. I understand that, by signing this form, I am confirming my authorization that the Company may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, please attach the documentation of personal representative designation and complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

IMPORTANT:

THIS AUTHORIZATION WILL NOT BE ACCEPTED AND IS NOT VALID UNLESS EACH SECTION IS COMPLETED.

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.