



Dear Member:

To facilitate the coordination of your care we may need to discuss your health information with an individual that you designate, or acquire health information from a third party. Before we can do so, you will need to complete and sign the enclosed Authorization for Release of Information form and include all necessary documentation.

Please complete, sign, and date the enclosed form. Once you have completed the form in its entirety and attached any legal documentation necessary please return the form to:

Optum ROI Processing Fax: 1-866-322-0051

OR

Optum
ROI Processing
11030 Optum Circle
Eden Prairie, MN 55344

Your prompt attention to this matter is greatly appreciated.

Sincerely,
Optum



Authorization for Release of Health Information

| | | | |
|-----------------------------|---------------|---------------------------|----------|
| _____ | _____ | _____ | |
| Individual's Full Name | Date of Birth | Member or Subscriber ID # | |
| _____ | _____ | _____ | _____ |
| Individual's Street Address | City | State | Zip Code |

I understand and agree that:

- this authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, 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;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- this authorization will expire one year from the date I sign the authorization. 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.

Who May Receive and Disclose my Information:

I authorize Optum and its affiliates to disclose my individually identifiable health information to the following person(s) or organization(s):

(Full Name of Person(s) or Organization(s))

(Full Address of Person(s) or Organization(s))

Type of Information to be Disclosed:

- I authorize disclosure of all my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; **or**
- I authorize only the disclosure of the following information:

(Type of Information)

Purpose of Disclosure:

- 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:

(Explain Purpose)

Signature of Individual

Date

Witness Signature *(For Illinois Residents Only)*

Date

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

Signature of Individual's Representative

Date

Personal Representative's:

Name

Phone Number

Street Address

City

State

Zip Code

(For California and Georgia residents only) I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS



Instructions for Completion
Authorization for Release of Information

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|--|--|
| 1. Demographical Information | Fill in your name, date of birth, address information and your subscriber ID. This information is required for identification and authentication purposes. |
| 2. I authorize Optum and its affiliates to disclose my individually identifiable health information to the following person(s) or organization(s): | Write the name and address of the individual(s) that you authorize Optum to disclose information to regarding your care. |
| 3. Type of Information to be Disclosed | Place a check mark in one of the applicable boxes. If the second box is checked write on the line provided the specific information we may disclose. |
| 4. Purpose of Disclosure | Place a check mark in one of the applicable boxes. If the second box is checked write on the line the specific purpose of the disclosure of your information. |
| 5. Signature of Individual | To be valid the authorization form must be signed and dated. For Illinois consumers, a witness signature is required. |
| 6. Personal Representatives | A personal representative who signs on the individual's behalf must provide legal documentation to verify his/her authority to do so. |

Nondiscrimination Notice and Access to Communication Services

Optum companies (together, “Optum”) provide services to health plans and other health programs or activities.

Optum does not exclude people or treat them unfairly because of sex, age, race, color, national origin, or disability.

Free services are available to help you communicate with us and with your health plan. Such as, letters in other languages, or in other formats such as large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free number on your member ID card. TTY 711.

If you think you weren’t treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Optum Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344
Phone: 888-445-8745, TTY 711
Fax: 855-351-5495
Email: Optum_Civil_Rights@Optum.com

If you need help with your complaint, please call the toll-free number on your member ID card. TTY 711. You must send the complaint within 60 days of when you found out about the issue.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free **1-800-368-1019, 800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Language Assistance Services & Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the toll-free number on your member ID card. TTY 711.

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| 13. Cushite-Oromo | HUBACHISA: Kan ati dubbattu Afaan Oromoo (Oromo) yoo ta'ee, tajaajilliwwan gargaarsa afaanii, kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa kanfaltii malee Waraqaa Eenyummaa keerratti tareefameetiin bilbili. |
| 14. Dutch | OPGELET: Indien u Nederlands (Dutch) spreekt zijn taalbijstandsdiensten gratis voor u beschikbaar. Gelieve het gratis telefoonnummer die u op uw identificatiekaart vindt te bellen. |
| 15. French | ATTENTION : Si vous parlez français (French) , des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification. |
| 16. French Creole-Haitian Creole | ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole) , ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w. |
| 17. German | ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an. |
| 18. Greek | ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (Greek) , υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους. |
| 19. Gujarati | ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે. કૃપા કરી તમારા આઇડેન્ટીફિકેશન કાર્ડ પર આપેલા ટોલ-ફ્રી નંબર પર કોલ કરો. |
| 20. Hawaiian | MALIU MAI! Inā 'ōlelo 'oe i ka 'ōlelo Hawai'i (Hawaiian) , loa'a ke kōkua unuhi manuahi no ke kōkua 'ana aku iā'oe. 'Olu'olu e kelepona aku i ka helu kelepona kahea manuahi i ho'opa'a 'ia ma kāu kāleka hō'ike pilikino. |
| 21. Hindi | ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें। |
| 22. Hmong | CEEb TOOM: Yog koj hais Lus Hmoob (Hmong) , muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej. |
| 23. Ibo | GEE NTI: Ọ bụrụ na ina asụ asụsụ Igbo (Igbo) , enyemaka na-ahazi asụsụ, bu n'efu, ịjịrị gị mgbe niile. Biko kpọọ ndị toll-free na nọmbà ekwentị nke edepụtara na kaadi njirimara gị. |
| 24. Ilocano | PAKDAAR: Nu saritaem ti Ilocano (Ilocano) , ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo. |
| 25. Indonesian | PERHATIAN: Jika Anda berbicara Bahasa Indonesia (Indonesian) , layanan bantuan bahasa akan tersedia untuk Anda secara gratis. Harap hubungi nomor telepon bebas pulsa yang tercantum pada kartu identitas Anda. |

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| 26. Italian | ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa. |
| 27. Japanese | 注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。 |
| 28. Karen | ဟံသုဂ်ဟံသးဘၣ်တက့ၢ်-ဖဲန့မ့ၢ်ကတိၤကညိၣ်ကျိၣ်(Karen)န့ၣ်,ကျိၣ်တၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်,လၢတလိၣ်ဟ့ၣ်အပူၤ,ဘၣ်န့ၣ်အိၣ်ဝဲဒၣ်လၢန့ၣ်လိၤ. ဝံသးစူၤကိးဘၣ်လိၣ်ဝဲစီၣ်နီၣ်ဂံၢ်လၢတၢ်ကိးအိၣ်လၢတလိၣ်ဟ့ၣ်အပူၤ,ဘၣ်လၢတၢ်ရဲၣ်လိၤဟံၤအိၣ်လၢန့ၣ်ဂီၢ်ခိၣ်အကးအလိၤန့ၣ်လိၤ. |
| 29. Korean | 알림: 한국어(Korean) 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오. |
| 30. Kru- Bassa | YI LÈ: I balè u mpòt Bassa (Bassa) , bot ba kòbòl mahòp yanga, bayé ha i nyuu hola wè. Sòhò, sébél i nsinga i yé ntilgaga i kat yòn i mbon nlon. U saa béé. |
| 31. Kurdish-Sorani | تێبینی: گەر بە کوردی سۆرانی (Kurdish Sorani) قسه دهکەیت، بێبهرامبەر خزمەتگوزاری زمانت لهبهر دهسته. تکایه پهیوهندی بکه به رهههم تهلهفونی بێبهرامبەر که له ناسنامهکهتا نووسراوه. |
| 32. Laotian | ກະລຸນາຟັງ: ຖ້າຫາກວ່າທ່ານເວົ້າພາສາລາວ (Laotian), ການບໍລິການຊ່ວຍເຫຼືອສໍາລັບການພາສາ, ບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ, ມີສໍາລັບທ່ານ ກະລຸນາໂທຫາເບີໂທລະສັບໂທລະສັບທີ່ລະບຸໄວ້ໃນບັດປະຈໍາຕົວຂອງທ່ານ. |
| 33. Marathi | कृपया लक्ष द्या: जर तुम्ही मराठी (Marathi) बोलत असल्यास, भाषा सहाय्य सेवा तुम्हाला मोफत उपलब्ध आहेत. कृपया तुमच्या ओळखपत्रावर दिलेल्या टोल फ्री कमांकावर संपर्क करा. |
| 34. Marshallese | LALE: Ñe kwōj kōnono Kajin Majeļ (Marshallese) , kwomaroñ bōk jerbāl in jipañ in kajin ejjeļok wōñāñ. Kwōn joun im kallōk nōmba eo ejjeļok wōñāñ im ej jeje ilo kaat in identification eo am. |
| 35. Micronesian-Pohnpeian | KANSENOH: Ma komw lokaiahn Pohnpei (Pohnpeian) , mie sawas en mahsen, soh isepe, ong komwi. Menlau, eker delepwohn nempe me soh isepe me ntingihdi ni pein omwi doaropwe idihada. |
| 36. Navajo | DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yániiti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shqódi ninaaltsoos nit'i'izi bee nééhozinígíí bine'déé' t'áá jíik'ehgo béesh bee hane'í biká'ígíí bee hodílnih. |
| 37. Nepali | ध्यान दें: यदि तपाईं नेपाली (Nepali) भाषा बोल्नुहुन्छ भने, तपाईंको निम्ति निशुल्क भाषा सेवा उपलब्ध छ। कृपया तपाईंको परिचय कार्डमा सूचीकृत फोन नम्बरमा कल गर्नुहोस्। |
| 38. Nilotic-Dinka | DETTIC: Na yi jam ë Thuonjäñ (Dinka) ke kuwony de wëër de thookyic abac atw alëu benë yi kony. Them ba cööt në namba de thiliñ yenë cööt abac cï gëör në wereñ dun ye yi nyuwoth köu. |
| 39. Norwegian | OBS: Hvis du snakker norsk (Norwegian) , kan du få gratis språkhjelp. Ring gratisnummeret som står på ID-kortet. |

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| 40. Pennsylvania Dutch | AADACHT: Wann du Deutsch Schwetze (Pennsylvanian Dutch) kann, kannscht du frei Schprooch aushilfe griege. Ruf die frei telefon Nummer uff dei eegne ID Kaart. |
| 41. Persian-Farsi | توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید. |
| 42. Punjabi | ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪਛਾਣ-ਪੱਤਰ 'ਤੇ ਦਿੱਤੇ ਗਏ ਟੋਲ ਫ੍ਰੀ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। |
| 43. Polish | UWAGA: Jeżeli mówisz po polsku (Polish) , udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej. |
| 44. Portuguese | ATENÇÃO: Se você fala português (Portuguese) , contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação. |
| 45. Romanian | ATENȚIE: Dacă vorbiți românește (Romanian) , vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la numărul gratuit tipărit pe cardul dumneavoastră de identitate. |
| 46. Russian | ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian) . Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте. |
| 47. Samoan-Fa'asamoa | FAAALIGA: Afai e te tautala Faa- Samoan (Samoan) , o loo avanoa tautua mo fesoasoani tau gagana mo oe, e le totogia. Faamolemole vili le numera o le telefoni e le totogia o lisi atu i lau pepa faamaonia. |
| 48. Serbo-Croatian | POZOR: Ako govorite hrvatski (Croatian) , možete besplatno koristiti usluge prevodioca. Molimo nazovite besplatni broj telefona koji se nalazi na vašoj identifikacijskoj karti. |
| 49. Somali | OGOW: Haddii aad ku hadasho Soomaali (Somali) , adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga. |
| 50. Spanish | ATENCIÓN: Si habla español (Spanish) , hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación. |
| 51. Sudanic-Fulfulde | MAANDOORE: (Fulani), to ada haala Ingilisre , walliinde wolde, caahu, e woodi ngam maada. Kusu noddu limngal telefol ngol caahu limtaangal nder kaatiwol ID maada. |
| 52. Swahili | TAHADHARI: Kama unazungumza Kiswahili (Swahili) , huduma ya msaada wa lugha, bure, inapatikana. Tafadhali piga namba ya bure iliyopo kwenye kadi yako. |

Insurance Benefit Plans

English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan's phone number at 1-XXX-XXX-XXXX

Someone who speaks (your language) can help you. If you need more help, call the CA Dept. of Insurance at 1-800-927-4357

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o plan de salud. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al 1-XXX-XXX-XXXX

Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357
(Spanish)

中文

請注意：您可以免費取得口譯員服務，與您的醫師或醫療保險計畫聯絡。
欲取得口譯員服務或詢問中文的書面資料，請先致電您的保健計畫，電話號碼
1-XXX-XXX-XXXX

我們有會說中文的人為您服務。若您需要其他協助，請致電 1-800-927-4357
與加州保險局聯絡。
(Chinese)

HMO Benefit Plans

English

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-XXX-XXX-XXXX

Español

IMPORTANTE: ¿Puede leer esta carta? Si no, alguien le puede ayudar a leerla. También puede recibir esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-XXX-XXX-XXXX
(Spanish)

中文

請注意：您是否能閱讀此信件？若您無法閱讀此信，我們將為您提供專員服務。
您也可以取得本信件的中文書面翻譯。欲洽詢免費服務，請立即致電
1-XXX-XXX-XXXX
(Chinese)