



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on your giving this authorization.

Effect of Granting This Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

SECTION A: Individual authorizing use and/or disclosure. – REQUIRED INFORMATION

Name: _____

Address: _____

Telephone: _____ Member Identification Number: _____

SECTION B: The use and/or disclosure being authorized. – REQUIRED INFORMATION

PHI to Be Used and/or Disclosed: (Specifically describe the PHI to be used and/or disclosed.)

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 (PHI).

Entities or Persons Authorized to Use or Disclose: (Name, or specifically describe, the persons and/or organizations – or the classes of persons and/or organizations – including UniCare, that are authorized to make use of and/or to disclose the PHI described above.) – **REQUIRED INFORMATION**

1. UniCare Life & Health Insurance Company _____ 3. _____

2. _____ 4. _____

Entities or Persons Authorized to Receive: (Name, or specifically identify, the persons and/or organizations – or the classes of persons and/or organizations – including UniCare, that are authorized to receive, and subsequently use and/or disclose, the PHI described above.) – **REQUIRED INFORMATION**

1. UniCare Life & Health Insurance Company _____ 3. _____

2. _____ 4. _____

Purpose of this Authorization:

At request of individual

For the following purposes:



SECTION C: Expiration and Revocation. – REQUIRED INFORMATION

Expiration: This authorization will expire (complete one):

- On ____/____/_____
- 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: UniCare – Andover Service Center
 Address: PO Box 9022, Andover, MA 01810-0922
 Telephone: 800-442-9300 Fax: 978-474-6800

INDIVIDUAL’S SIGNATURE – REQUIRED SECTION

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name: _____

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative’s Name: _____

Signature: _____ Date: _____

Relationship to Individual: _____

RETURN COMPLETED FORM TO:

**UniCare
 Andover Service Center
 P.O. Box 9022
 Andover, MA 01810-0922
 Attention: Customer Service Supervisor**

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.