ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Authorization for Release of Health Information

Member's Full Name	Date of Birth	Member or Subscriber ID #

Member'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;
- I may revoke this authorization at any time by notifying Rocky Mountain Health Plans (RMHP) in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

This authorization expires (choose one):

☐ When plan terminates (including any gap in coverage)
☐ On this specific date:
☐ When this event occurs (specify):

Who May Receive and Disclose my Information:

I authorize Rocky Mountain Health Plans and its affiliates to receive from or 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))
(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 Member Date

The authorized can make the following changes: ☐ Address Change ☐ Enrollment/Disenrollment

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

POA, Guardian, or Representative:

_____ _____
Name Phone Number

_____ _____ ____ _____
Street Address City State Zip Code

_____ _____
Signature of POA, Guardian, or Representative Date

For help in completing this form, please call our Customer Service at 888-282-1420 (TTY dial 711). Hours are 8am – 8pm, 7 days/week, October 1-March 31, and 8am – 8pm, M-F, April 1-September 30.

Please return this form (and documentation, if applicable) to:
Mail: RMHP
PO Box 10600
Grand Junction, CO 81502-5600

Fax: 970-244-7880
Email: Customer_Service@rmhp.org

Notice of Nondiscrimination
Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-346-4643 (TTY: 711).
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-346-4643 (TTY: 711).