Optum Business area/system: Optum Idaho

Authorization for Release of Health Information/Person- Centered Service Plan

Member's Full Name:

Member's Date of Birth:

Member's Medicaid ID#:

Member/Family's email:

Member/Family's phone:

Date of Current Person-Centered Service Plan:

Name of Targeted Care Coordinator:

Purpose of Disclosure:
My health information included within my Person-Centered Service Plan is being disclosed at my request and/or at the request of my personal representative (e.g., if applicable under state law, parent(s) or legal guardian. **Please note:** If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

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, 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 my Targeted Care Coordinator in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

I authorize my Targeted Care Coordinator listed in my Person Centered Service Plan which is stored in Optum Supports and Services Manager ("OSSM") and operated by

Optum/United Healthcare, to disclose the individually identifiable health information contained in the Person-Centered Service Plan dated above to the following person(s) or organization(s):

First & Last Name*/Organization	Phone*	Email*	Role

*Required fields

Start Date of Access: _____
End Date of Access (if earlier than one year): _____
Consent will end after one year and will need to be renewed on a new form.

I authorize disclosure of all my health information contained in the Person-Centered Service Plan dated above, and access to the related OSSM Individual and Support Team Portal ("Portal"), which may include details about the Child and Family Team meeting times and dates, team members, assessment scores, and notes. The Person-Centered Service Plan may include medical, pharmacy, dental, vision, mental health, substance use, HIV/AIDS, psychotherapy, reproductive, genetic, communicable disease and health care program information. This information may include, for example, information relating to visits, admissions, treatment, case management or care coordination.

☐ Optional: If you would like someone to manage Portal access on your behalf, and thereby have access to the above referenced information, please check the box to the left and indicate the person(s) here:

First & Last Name*/Organization	Phone*	Email*	Role

* Required fields if you select this option

_____
Signature of Member Date

_____
Signature of Parent/Guardian/Legal Representative 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.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS