

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;
- this authorization will expire one year from the date I sign the authorization. I may revoke this
 authorization at any time by notifying UnitedHealthcare 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 UnitedHealthcare and its affiliates to receive from or disclose my individually identifiable health information to the following person(s) or organization(s):

Naturally Nurtured Birth Services

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

3514 Winhoma Drive Memphis, TN 38118_

(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:

Purpose of Disclosure:

- X 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)				
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Signature of Member		Date	ate	
Witness Signature (For Illinois Residents Only)		Date		
Please note: If you are a copy of your legal author				
Guardian or Representativ	e:			
Name	Phone Numb	per		
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 FORM FOR YOUR RECORDS AND RETURN IT TO:

Naturallynurturedbirth@gmail.com