Optum Frontier Therapies™

Authorization to use and disclose Protected Health Information (PHI)

Optum Frontier Therapies ®, cannot disclose PHI without consent from the patient that the information is about. We use this form to obtain your written consent to disclose your PHI to someone designated by you. This request does not allow your designated person to make any of your treatment decisions or direct care decisions. Use this form to give authorization for the PHI detailed in Section 3 to be shared with your designated person, named in Section 2 below. When filling out this form, provide your most current information

1 Patient information (please provide current information)

Last name First name MI

Mailing street address Apt. #

City State ZIP

Member ID number

Date of birth (mm/dd/yyyy) Phone number with area code

2 Designated person information

I authorize Optum Frontier Therapies to use and disclose my PHI to the person(s) or organization(s) designated below. I understand that there are certain parties that must protect the privacy of my PHI. These are health care providers and other parties who are required to do so under federal or related state laws. If my designated person is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by them without my permission.

Authorized person #1

Name Phone number with area code

Mailing street address Apt. #

City State ZIP

Relationship to patient

Authorized person #2

Name Phone number with area code

Mailing street address Apt. #

City State ZIP

Relationship to patient

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3 Description and purpose of disclosure

Select the company that applies to your request: ☐ Optum Frontier Therapies

The following items require special consent by law. Check the boxes below to indicate your intent to include:
☐ Alcohol or substance abuse ☐ Genetic information ☐ HIV / AIDS ☐ Mental or behavioral health ☐ Reproductive health

Please describe the information covered by this consent, and the purpose of the disclosure. I understand that by leaving this section blank, I am authorizing the disclosure of all of my PHI, including my patient profile and pharmaceutical records, to my authorized representative(s).

Description:

4 Expiration and revocation

Recipient of PHI (select only one option)
I understand that this consent will expire thirty six (36) months from the date of my signature as noted below unless I revoke in writing, request a different date below, or am a resident of a state that requires a shorter time frame.

If I wish for my consent to expire on a different date, noted here:

For those residing in states below, the expiration date cannot exceed:

12 months: MD, MN 24 months: MT, VA, Puerto Rico 30 months: ME

5 Signature

A. Authorized person designated by patient:

I have read and understand the above information. I acknowledge that by signing this form, I understand that my decision of whether or not to sign this form will not affect my eligibility for treatment or payment and am voluntarily giving consent to Optum Frontier Therapies and its affiliates to use and/or disclose my PHI to the person(s) or organization(s) designated in Section 2.

Signature of patient: Date:

B. Personal representatives who are legally appointed:

I have read and understand the request and acknowledge that by signing this form I have the legal authority to act on behalf of the patient, and am attaching the appropriate documentation to this request.

Signature of Personal Representative: Date:

6 Please mail the completed form to (Please keep a copy of this form for your records.)

Optum Frontier Therapies
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Las Vegas, NV 89118

Fax: 1-866-991-9929