Optum

AUTHORIZATION FOR THE RELEASE OF INFORMATION

By signing this form, I authorize Optum to release the medical records of:

Patient's full name:_____Date of Birth_____/_____/_____

Address: _____

City:_____State:_____Zip Code:_____Phone: ( )_____

Optum Medical Care of New Jersey (formerly Riverside Medical Group) Provider or Clinic Name:

_____

Release records to:

Recipient(s) _____

Address: _____

City:_____State:_____ Zip Code:_____ Phone: ( )_____

Reason for the Release of Information:

- ☐ At the request of the individual (Patient)
- ☐ Other (specify):_____

Information to be released:

- ☐ Medical Record for past 3 years
- ☐ Date(s) of Service:_____to _____
- ☐ Entire Medical Record *(including billing, radiology studies and records from prior providers)*

☐ Medical History, Evaluation Records	☐ Radiology Reports	☐ Laboratory Results
☐ Cardiology Results	☐ Immunizations	☐ Prescription Data
☐ Consultation Documentation	☐ Surgical Reports	☐ Summary of Record

- ☐ Other (specify): _____

Include: (Indicate by Initialing) *

_____ Alcohol/Drug Treatment	_____ HIV- Related Information
_____ Mental Health Information	_____ Genetic Information
_____ Reproductive Health Care Services	

*I understand that the records released may include sensitive information including substance use disorder, HIV/AIDS, communicable and sexually transmitted disease, mental health, genetic testing, and reproductive health care services.

Authorization to Discuss Health Information:

☐ By initialing here _____ I authorize _____ to discuss my health information with my attorney, or a governmental agency, listed here:

_____

Revocation: I have the right to revoke this authorization at any time by writing to Optum. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Redisclosure: I understand that the information released according to this authorization may be subject to redisclosure by the recipient(s) and no longer protected under HIPAA federal law.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Signature of Patient *(*or representative authorized by law)**:*** _____

Print Name: _____

Relationship *(if you are not the patient):* _____ **Today's Date:** _____

Expiration Date/Event: _____ *(If none specified, the Authorization remains valid for one year from the date of signature).*

***Optum may require court documentation verifying your authority to sign on behalf of the patient.*

Kindly complete the form in its entirety and return completed form to the address or fax number listed below. You may also contact us at the phone number below should you have any questions relating to completing this form:

Optum Medical Care of New Jersey

Health Information Management Department

3 Delaware Drive, Suite 206

Lake Success, NY 11042

Phone: 551-257-7601 Fax: 551-257-7595

Office use only**:** Date received: ____/____/____ Received by (Print Name/Initial): _____

Ticket: _____ Date completed: ____/____/____ ❑Faxed ❑Mailed ❑Emailed ❑Picked up