UNICARE®

Authorization

Health plan administered or insured by any of the following: UNICARE Life & Health Insurance Company, UNICARE Health Insurance Company of the Midwest (IN and IL), UNICARE Health Plans of the Midwest, Inc. (HMO in IN and IL only) or UNICARE Health Insurance Company of Texas (TX only), UNICARE Health Plans of Texas, Inc. (HMO in TX only), UNICARE Health Plans of Virginia, Inc. (HMO in VA only) or UNICARE Health Plan of Oklahoma, Inc. (HMO in OK only).

Section A: Individual authorizing use and/or disclosure.

Name				Phone No.
Address	City	State	ZIP Code	Member Identification No.

Section B: The use and/or disclosure being authorized.

PHI to Be Used and/or Disclosed: **{Specifically describe the PHI to be used and/or disclosed}**

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information (PHI).

Entities or Persons Authorized to Use or Disclose: **{Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose the PHI described above}**

Entities or Persons Authorized to Receive: **{Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above}**

Purpose of this Authorization: ☐ At request of individual. ☐ For the following purposes:

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

Section C: Expiration and revocation.

Expiration: This authorization will expire (complete one):

☐ On _____/_____/_____

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office	Phone No.	Fax No.	Address

Individual's Signature

I, ______________________________, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name	Signature	Date

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name	Signature	Relationship to Individual	Date

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

®WellPoint Health Networks Inc.