



Authorization for Release of Protected Health Information

Fill out **completely** to prevent delay

Submit form:

Fax: (630) 236-4380

Mail: UNITE HERE HEALTH

PO Box 5348, Oak Brook, IL 60522

For help, call:

The UHH/member number on the back of your medical ID card OR if you have Kaiser or Tufts Health Plan medical, call UHH at:

- (833) 637-3519 (DC/Baltimore area)
- (844) 267-4325 (Boston)
- (855) 484-8480 (LA/OC area)
- (844) 639-8657 (Colorado)

- Check one: ☐ I am the employee (*I get insurance coverage through my job*)
 ☐ I am a dependent (*I am in the employee's family and he/she provides my coverage*)

1: Employee Information

Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yy)	SS # or Member ID #	Phone
Street		Apt #	City	State	Zip

2: Dependent Information

Full Name	Relationship to Employee	Date of Birth	Age	Phone
Street	Apt #	City	State	Zip

What is the purpose of this authorization? (*check one*):

- ☐ At my request ☐ For a different purpose _____

I want UNITE HERE HEALTH to discuss and/or release ☐ my or ☐ my dependent's health information to the following person or organization:

Person/organization _____ Phone number _____

Relationship to me (*my sister, doctor, lawyer, etc.*): _____

I want UNITE HERE HEALTH to release the following information to the person named above (*check all that apply*):

- ☐ ANY and ALL information ☐ Explanation of Benefits ☐ Eligibility ☐ Enrollment ☐ Appeal ☐ Itemization of Lien

☐ Other _____

I want this authorization to expire (*check one*):

- ☐ Not until I revoke ☐ On this date (*please specify*): _____

☐ When the following event occurs _____

If I don't check a box, this authorization will expire in one year.

I, _____, authorize the use or disclosure of health information as described above. I have read and understand the contents of this form. I understand that UNITE HERE HEALTH cannot control information after it is released. I understand that this request may include reports, correspondence, test results, diagnosis, or medical procedures. I understand that I can revoke (cancel) this Authorization at any time by notifying UNITE HERE HEALTH's Privacy Officer in writing, but revoking will not affect information already released. If I revoke this Authorization, additional information will not be released, except where permitted or required by law. I am signing this form voluntarily. If I do not sign this Authorization, my ability to obtain treatment, payment, enrollment, or eligibility for benefits with UNITE HERE HEALTH does not change. ***By signing and dating this form, I am allowing UNITE HERE HEALTH to share my/my dependent's health information with the person or organization named above.***

3: REQUIRED Signature and Date

Signature of the person authorizing release of health information	Date			
Print Name	Relationship to Employee	State	Zip	
For Office Use Only	Date Received	Received By	Copy Mailed On	Copy Given to Patient On