



A UnitedHealthcare Company

### AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR CUSTOMER SERVICE

(Optional Authorization – You are not required to sign)

Please clearly print all information.

For the purpose(s) of customer service and related activities, I, the Customer, hereby agree, on my behalf and on behalf of my minor dependents, that information available regarding coverage or any claim regarding me or my minor dependents may be released by American Medical Security Life Insurance Company, PacifiCare Life and Health Insurance Company, and/or PacifiCare Life Assurance Company (collectively PacifiCare) to me, my spouse, my parents (for dependents age 18 or over), my medical providers, my agent(s) of record, as applicable, or as may be otherwise lawfully permitted, or as I may further authorize in the box below.

**OPTIONAL Additional Authorized Individuals – Please Print Clearly.**

I additionally authorize the following individual(s) to receive the above-named information.

Full Name	Relationship to Customer
Full Name	Relationship to Customer

I understand that an authorization is not needed for disclosures related to my or my minor dependents' treatment, the payment for such treatment, or related health-care operations as defined under 45 CFR parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the authorized recipient and may no longer be protected by state or federal privacy law. This authorization does not apply to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on this authorization. I understand that I may refuse to sign this authorization. Should I choose to sign this authorization, I understand that I have the right to request access to my protected health information that may be used or disclosed.

**Information Needed To Identify Your Plan - Please Print Clearly:**

Primary Customer Identification Number: \_\_\_\_\_  
(See ID card for Customer Identification Number)

Customer's Signature	Date	Print Customer's Full Name
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*For child only, signature must be the child's parent or legal guardian if Customer is not of legal age.*

If signed by a legal representative of Customer, please indicate the legal representative's authority to act on behalf of Customer.

Legal Representative's Signature	Authority	Date
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Spouse/domestic partner's Signature (if spouse/domestic partner is covered)	Date
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Signature of each Covered Dependent age 18 and over

Dependent's Signature	Date	Dependent's Signature	Date
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For copies of this authorization, visit [www.eAMS.com/pacificare](http://www.eAMS.com/pacificare) and click on Privacy Policy or call (800) 232-5432, press 1 at the prompt and then enter Ext. 15201. You may fax authorizations to (920) 661-4415 or mail them to American Medical Security, Attn: Imaging Department, P.O. Box 19032, Green Bay, WI 54307-9032.

Policy Identification Number

*For office use only.*