You have the right to privacy—and the right to decide who can access your information.

Protecting your right to privacy is important. UnitedHealthcare cares about your privacy, and we try to provide the best possible experience for our insured members.

Information about your health insurance coverage cannot be given out without your permission. If you would like to allow someone, such as a spouse, relative, or friend, to help you with your health insurance, please review and completely fill out the Authorization for Release of Information Form.

What you need to do.

Completion and return of this form is voluntary. This will allow UnitedHealthcare to release your account and health information to the person(s) listed. Please remember that this concerns your personal records and only you or your legal representative (such as a power of attorney, guardian or conservator) can give permission for someone to have access to them.

The authorization is on the next page. Please complete and return the form and mail it to the address at the bottom of the form.

Tip: You may wish to make a copy for your records.

You can also authorize certain family members over the phone by calling UnitedHealthcare Customer Service.

Call toll-free: 1-800-523-5800, TTY 711.

- Weekdays: 7 a.m. to 11 p.m., Eastern Time
- Saturday: 9 a.m. to 5 p.m., Eastern Time

Thank you for choosing UnitedHealthcare.

Authorization for Release of Information Form

Insured Member Name _____ **(Please print name)**

AARP Membership Number _____ **(Please print number)**

I hereby authorize UnitedHealthcare Insurance Company, and affiliates (UnitedHealthcare):

- to disclose my account and health information to the person(s) listed below, and/or
- to allow limited transactions, by the person(s) listed below, on my account for my AARP®-branded Supplemental or Personal Health Insurance Plan.

I understand that this authorization is voluntary.

Please print the name(s) of the individual(s) you are authorizing.

NAME	RELATIONSHIP	PHONE NUMBER

I understand this authorization will be valid until I notify UnitedHealthcare in writing. However, if I do stop this authorization, it will not have any effect on any information released previously by UnitedHealthcare.

I understand that the individual(s) listed above may, at any time, release any information received. UnitedHealthcare cannot guarantee the individual(s) will not use or disclose the information in violation of any applicable privacy laws.

INSURED MEMBER'S SIGNATURE DATE (DD/MM/YYYY)

Send this completed form to:
UnitedHealthcare
PO BOX 9003
Huntingdon Valley, PA 19006-9998