AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION

This authorization must be dated and signed by the individual or by a person authorized by law to give this authorization. File copy and facsimile transmission are considered equivalent to the original (unless applicable state law provides otherwise). If UnitedHealthcare seeks the authorization from an individual for a use or disclosure of Protected Health Information (PHI), UnitedHealthcare must provide the individual with a copy of the signed authorization.

I authorize United HealthCare Insurance Company, and its subsidiaries/affiliates ("UnitedHealthcare"), to use or disclose my medical, claim, or benefit records, including any individually identifiable health information contained in these records, as described below. I understand these records may contain information created by other persons or entities, including physicians and other health care providers as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services [Note: Psychotherapy notes may be used/disclosed only pursuant to a separate authorization pertaining only to psychotherapy notes], reproductive health services, and treatment for sexually transmitted diseases.

1. Persons/entities authorized to receive the information (including address of where information should be sent, if applicable):

   Name: University of Miami - Student Health Service

   Address: 5555 Ponce de Leon Boulevard, Coral Gables, FL 33146

2. Type of information UnitedHealthcare is authorized to use or disclose:

   _____

   _____

3. The information will be used or disclosed for the following purposes:

   _____

4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my enrollment in the health plan, eligibility to receive benefits, ability to obtain treatment, or ability to receive payment for treatment, unless allowed by law.

5. I understand that I may revoke this authorization at any time by notifying UnitedHealthcare in writing at the address on the back of the member's identification card, except to the extent that:
   (a) UnitedHealthcare has taken action in reliance on this authorization; or
   (b) If authorization was obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

6. This authorization expires [on] [upon] _____[date] or is valid _____ [event]. Please note: This authorization may be valid for a maximum time period of one year.

7. UnitedHealthcare will not receive compensation from a third party for using or disclosing this information.

I understand that once health information about me has been disclosed by United HealthCare Insurance Company to a third party, the health information may no longer be protected by federal privacy laws.

X _____

Printed name of individual or individual's representative

_____

If representative, relationship to individual and authority to act for individual

X _____ _____ X _____

Signature of individual **Subscriber Id #** **Date**

Please return the form to: UnitedHealthcare
P.O. Box 30555
Salt Lake City, UT 84130
Fax # (801) 938-2105

Form: AUTH UNI 011504