Optum Financial®

Authorization for Release of Personal Information

Complete this form to authorize the release of personal, individually identifiable information on your account(s) to others (i.e., spouse, physician, dependent, etc.), which may include electronic communications and protected health information (PHI).
Questions? Call the number on the back of your debit card if you have any questions while completing this form.

1035 CO HSA MSA

1 Participant information

Account holder name:

Last 4 of SSN:	**Date of birth:**

Telephone #:

Address:

City, State ZIP:

2a Authorized recipient(s)

Person(s) authorized to receive and use my personal information:
____ **By initialing here,** I authorize the Recipient(s) listed below to receive my personal information, which may include PHI. I also understand that if I fail to list an expiration date below, that each Recipient's authorization will expire twelve (12) months from the date this form is signed. I further understand that if I wish to remove authorization for a Recipient in the future, I must submit a new form with Section 4 completed.

Recipient:	**Expiration date:**
Recipient:	**Expiration date:**
Recipient:	**Expiration date:**

2b Type and purpose of authorization

Please select ONE of the account(s) access types below:

☐ Full account(s) privileges:
____ **By initialing here,** I authorize full account(s) privileges to be granted to the Recipient(s) listed in Section 2a and understand that this allows these individual(s) to receive all my personal, individually identifiable information, which may include PHI, for the purposes of submitting claims, required documents and/or making changes to one or more of my accounts. I also understand that these account(s) privileges include, but are not limited to, resetting web access sign in credentials, requesting payment cards, and/or changing information on my account(s).

☐ Limited account(s) privileges:
____ **By initialing here,** I authorize limited account(s) privileges to be granted to the Recipient(s) listed in Section 2a and understand that this allows these individual(s) to receive all my personal, individually identifiable information, which may include PHI, but does not allow the Recipient(s) to make or authorize changes to one or more of my accounts.

Please explain why these individual(s) need privileges on your account(s):

Continued next column >>>

3 Participant authorization and signature

By signing below, I understand and agree that this Authorization is completely voluntary. I further understand that generally the payment of health care claims, enrollment in the health plan(s), and eligibility for benefits may not be conditioned upon the signing of this Authorization, unless permitted by Federal Health Information Privacy Laws. The authorization remains in effect until revoked or until the expiration date, even in cases of death. I understand that I may revoke any Recipient(s) identified in this Authorization by submitting this form (with Sections 1, 2a and 4 completed) to Optum Bank at the address indicated below; however, this will not have an effect on any actions taken before receiving the revocation request. I also understand my PHI may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease, and/or health care program information. I further understand that the PHI identified in this Authorization may be disclosed to and/or received by persons or entities that are not health plans, health care providers, or health care clearinghouses subject to Federal Health Information Privacy Laws. This means that once disclosed pursuant to this Authorization, PHI may no longer be protected by Federal Health Information Privacy Laws and the identified PHI may be subject to disclosure by the Recipient(s).

By signing below, either I authorize, or my other designated legal representative authorizes (I've attached evidence of signer's authority to sign on my behalf), Optum Bank to release the identified personal information to the Recipient(s) specified in this Authorization.
(For California and Georgia residents only) I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

✗ _____ _____
Account holder signature — Date

✗ _____ _____
Witness signature (for Illinois residents only) — Date

4 Removal of authorized recipient(s)

Complete this section along with Section 1 of this form if you wish to remove authorization for a previously identified Recipient(s) to receive your personal information.
By signing below, I authorize the removal of the designated Recipient(s) indicated below. I understand that all information and notifications from the Plan will be directed back to me, and that this removal will not have an effect on any actions Optum Bank took before it received this removal request. This request does not apply to website and/or electronic communications access. If you have shared your sign-in credentials, which may have resulted in a change by a previously authorized party or authorized representative, you will need to change them as appropriate.

Recipient:	**Expiration date:**
Recipient:	**Expiration date:**
Recipient:	**Expiration date:**

✗ _____ _____
Account holder signature — Date

✗ _____ _____
Witness signature (for Illinois residents only) — Date

*If Participant is unable to sign this form for the reasons outlined below, the Participant's Legal Representative must provide one of the following in order to sign on the Participant's behalf:

1) **If the Participant is deceased,** the Legal Representative must provide documentation that he/she is the executor or administrator of the Participant's estate. Please note that after death of the Participant, we cannot accept a Durable Power of Attorney, Advance Directive, Guardianship or Conservatorship papers as they are no longer valid.

OR

2) **If the Account Holder/Participant is incapacitated,** and as a result, a Legal Representative needs to act on behalf of the Participant, submit this completed Authorization Form and include the legal documentation indicating the identity and authority of the Legal Representative. Legal documentation includes a Durable Power of Attorney, Guardianship or Conservatorship papers.

PLEASE RETAIN COPY OF THIS FORM FOR YOUR RECORDS.
Where to return your form?
By mail: Optum Bank, P.O. Box 271629, Salt Lake City, UT 84127
By fax: 1-866-314-9795 By email: HSAforms@optum.com
Note: Forms without a signature will not be processed