United Healthcare Community Plan

ROCKY MOUNTAIN HEALTH PLANS
A UnitedHealthcare Company

Revocation of Authorization for Release of Health Information

Use this form to revoke or take away permission to get or share health information.

Member's Personal Information

Full Name ____

Address ____

City ____________________________________ State _______ ZIP ______________

Date of Birth ______________________

Member or Subscriber ID Number __________________________

Who is being revoked from getting and sharing my information?

I revoke permission for UnitedHealthcare and its affiliates to obtain from or share my health information with:

____

Full name of person(s) or name of organization(s)

____

Full name of person(s) or name of organization(s)

Signature

By signing below, I understand and agree that:

- This revocation is voluntary.
- I may not be denied treatment or payment for health care if I do not sign this form. I may not be denied eligibility for health care if I do not sign this form.
- Cancellation of my permission is effective on the date my request is processed.

____ ________________________

Signature of Member or Member's Representative Date

____ ________________________

Witness Signature *(For residents of Illinois only.)* Date

Note: If you are a guardian or court appointed representative, please complete the section on the back of this page. You must also attach a copy of your legal authorization to represent the member.

Guardian or Court Appointed Representative Information

Full Name ____

Address ____

City _______________________________________ State _______ ZIP ______________

Phone Number _______________________

Ready to send the completed form?

Send the signed and completed form to:

UnitedHealthcare Community and State
PO Box 30753
Salt Lake City, UT 84130

Fax: 1-844-386-9286

Please keep a copy of this form for your records.

Civil Rights Notice

Discrimination is against the law. Rocky Mountain Health Plans complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation.

Rocky Mountain Health Plans provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Rocky Mountain Health Plans provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call Member Services at **1-800-421-6204** (TTY/TDD **711**).

If you believe that Rocky Mountain Health Plans has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation, you can file a grievance with:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: **ocrportal.hhs.gov/ocr/portal/lobby.jsf**

By mail:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

By phone: **1-800-368-1019** (TDD: **1-800-537-7697**)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

1-800-421-6204, TTY 711

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the toll free number above.

Español: ATENCIÓN: Si habla español, los servicios de asistencia de idiomas están disponibles para usted sin cargo. Llame al número de teléfono gratuito que se indica arriba.

Tiếng Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số điện thoại miễn phí ở trên.

中文： 注意：如果您說中文，您可獲得免費語言協助服務。撥打上方免費電話。

한국어: 참고: 한국어를 구사하시는 경우, 통역 서비스를 무료로 이용하실 수 있습니다. 상기 수신자 부담 전화번호로 전화하십시오.

Русский: ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете бесплатно воспользоваться помощью переводчика. Позвоните по указанному выше бесплатному номеру.

አማርኛ፦ ትኩረት፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች፣ በነጻ ክፍያ፣ ለእርስዎ ይገኛሉ። ከላይ ባለው ከክፍያ ነጻ ቁጥር ይደውሉ።

العربية: تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوفر لك مجانًا. اتصل بالرقم المجاني أعلاه.

Deutsch: HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Rufen Sie die oben aufgeführte kostenfreie Nummer an.

Français : ATTENTION : si vous parlez français, vous pouvez obtenir une assistance linguistique gratuite. Composez le numéro gratuit ci-dessus.

नेपाली: ध्यान दिनुहोस: तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। माथिको टोल

Tagalog: PANSININ: Kung nagsasalita ka ng Tagalog, may magagamit kang libreng mga serbisyong pantulong sa wika. Tawagan nang libre ang numero sa itaas.

日本語: 注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。上記のフリーダイヤル番号までお電話ください。

Afaan Oromoo: XIYYEEFFANNOO: Afaan Oromoo dubbattu yoo ta’e, tajaajilli gargaarsa afaanii, kaffaltii malee isiniif ni argama. Lakkoobsa waamicha bilisaa armaan olii irratti bilbilaa.

فارسی: توجه: اگربه زبان فارسی صحبت می‌کنید، خدمات ترجمه زبان به صورت رایگان به شما ارائه خواهد شد. با شماره رایگان بالا تماس بگیرید.

Polski: UWAGA: Jeżeli mówisz po polsku, dostępne są bezpłatne usługi wsparcia językowego. Zadzwoń pod darmowy numer podany powyżej.