Request for access to protected health information

You have a right to access and inspect records containing your protected health information (PHI) that Optum keeps and uses to provide services to you. According to the Health Insurance Portability and Accountability Act, these records are called the Designated Record Set (DRS).

Use this form to state the type of records you need and provide the date range for your request. Be as specific as possible.

Optum may impose a reasonable, cost-based fee for a copy of your protected health information, as permitted by the Privacy Rule.

Optum will respond to requests submitted by your authorized representative, such as a parent, court-appointed representative or other family member, provided your representative is authorized by you to receive your PHI. However, we may ask for more information from you or your authorized representative to verify the right to act on your behalf.

Your request for a DRS applies only to services provided by Optum. To obtain other PHI regarding services or benefits not provided by Optum, contact the company that provides those services or benefits.

If we are unable to send a copy of your DRS within 30 days from the date we receive your request, we will let you know about the delay.

If you have questions about this form, please call 1-800-777-3574 and speak with a customer service advocate.

Request for access to protected health information

Use this form to request access to your protected health information (PHI) from Optum. When filling out this form, please complete all sections, print information clearly and provide your most current information. Once the request is approved, a copy of your PHI will be mailed to you or your authorized representative.

1. Member information

Last name _____ First name _____ Middle initial _____

Mailing street address _____ Apt. # _____

City _____ State _____ ZIP _____

Date of birth (mm/dd/yyyy) _____ ☐ M ☐ F Gender _____ Phone number with area code _____

Date of injury (mm/dd/yyyy) _____

2. Type(s) of information requested

Please choose one of the options to indicate what type(s) of information you would like to receive:

☐ Option 1: A report that summarizes my order history

☐ Option 2: Other PHI. Please describe:

3. DRS format

I would like this information provided to me as follows:

☐ Hard paper copy by mail

☐ Electronic sent via secure email to this email address: _____
Electronic format requested (DRS will be sent as PDF documents if the date range below is left blank): _____

4. Date range of information requested

I would like this information for the following dates: From (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____

5. Member/authorized representative signature

I authorize the release of my protected health information to be sent to me; to others as directed in a signed authorization; or to others authorized to act on my behalf, at the address stated in Section 1 of this form. I understand that this request does not apply to certain types of disclosures, including for treatment, payment or health care operations.

Patient or authorized representative signature _____ Date _____

Important: If legal documentation is not on file with OptumRx, the authorized representative, including the parent, legal guardian, or executor of an estate, must attach a copy of legal documentation to this form.

Authorized representative's name _____ Phone number with area code _____

Mailing street address _____ Apt. # _____

City _____ State _____ ZIP _____

Relationship to patient and Authority to Act for member _____

6. Please mail the completed form to:

Optum, Attn: Medical Records 175 Kelsey Lane, Tampa, FL 33619

or fax to: 1-888-579-0064

Please keep a copy of this form for your records. You also have the right to receive a copy of this authorization.