Optum

Request for Access
(Get a Copy of Your Healthcare Information (Records))

Complete this form to request a copy of protected health information (PHI) maintained and used to make decisions about your **behavioral health** or **Employee Assistance Program (EAP)** benefits that are managed by Optum. Under HIPAA, this is called the Designated Record Set (DRS). Please complete each section below. Forms submitted with incomplete information, insufficient legal authority, or signed by the incorrect individual may result in processing delays.

If applicable, you may be able to obtain **claims and Explanation of Benefits** documentation from your online account at www.liveandworkwell.com by logging in and selecting *Manage Claims*.

If you have questions about this form, call customer service at the telephone number located on your health plan ID card. For assistance with healthcare information not managed by Optum, contact that entity directly.

Optum may impose a reasonable, cost-based fee for a copy of your PHI, as permitted by the HIPAA Privacy Rule and state law.

Requesting Access to Another Individual's Records

Please have the **member** sign and submit the request if:

1. you are not the legal representative, OR
2. the individual is 12 or older, and the records may relate to sensitive health information, such as mental health, substance use, HIV/AIDs, STD, pregnancy, or reproductive health.

If you qualify as a legal representative, you are required to attach supporting documentation:

- **Power of attorney, Court Order, or another valid document**
- **HIPAA authorizations do not establish legal authority and are not sufficient to submit an access request through this process**

Return the completed form via
Fax: 888-371-7011
Mail: Optum Privacy Administrator, 11000 Optum Circle, MN101-E013, Eden Prairie, MN 55344

Section 1: Requestor information & contact details

I am submitting this request for my: ☐ Self ☐ Minor child ☐ Someone else (describe relationship) _____

Preferred contact for questions: ( ) _____ ( ) _____ _____

Home Phone *Cell Phone* *Email Address*

Section 2: Member whose information is being requested

_____ _____ _____

First Name *Middle Initial* *Last Name*

_____ ( )

Date of Birth *Phone Number*

Address

_____ _____ _____

City *State* *ZIP Code*

Section 3: Subscriber information as it appears on subscriber's health plan ID card

_____ _____ _____

Subscriber Identification Number *Group Number* *Employer*

☐ Check here if the subscriber is the member and information is same as in Section 2 (skip to next section)

_____ _____ _____

First Name *Middle Initial* *Last Name*

( )

Phone Number

Address

_____ _____ _____

City *State* *ZIP Code*

Section 4: Legal representative (Required if requestor is not the member)

_____ _____ ( )

First Name *Last Name* *Phone*

Relationship to member ☐ Parent or legal guardian

☐ *Someone else (describe relationship) _____

**Attach supporting documentation*

Section 5: Type of PHI requested

I would like to request the following type(s) of information (*Check all that apply*):

Some information, such as recordings of phone calls maintained for quality assurance purposes or PHI not used to make decisions about individuals, is not contained within the DRS and may not be provided.

Behavioral Health (Mental health, substance abuse)	☐ Summary of Claims Documentation ☐ Claims & Explanation of Benefits ☐ Treatment Authorizations	☐ Appeals/Complaints Information ☐ Clinical Management Notes ☐ Other (specify below)
Employee Assistance Program (EAP)	☐ Summary of Claims Documentation ☐ Claims & Explanation of Benefits ☐ Treatment Authorizations	☐ EAP Notes ☐ Other (specify below)
Life Solutions	☐ Clinical Management Notes ☐ Assessments	☐ Other (specify below)

Other _____

_____

I would like this information for the following dates: _____ _____

Start Date (MM/DD/YYYY) *End Date (MM/DD/YYYY)*

Section 6: Recipient and format of PHI

Recipient of the PHI (*Select only one option*)

☐ **Option 1:** Myself (the member)

☐ **Option 2:** Someone else _____ _____ _____

Recipient First Name *Recipient Last Name* *Relationship*

Format of the PHI (*how and where should we send the records*)

☐ **Option 1:** PDF sent by secure email to _____

Email Address

☐ **Option 2:** Paper copy sent in the mail to the address below (*complete if different from Section 2*)

☐ **Option 3:** Other readily producible electronic format sent to the address below (*complete if different from Section 2*). Please describe:

_____

_____

Address

_____ _____ _____

City *State* *ZIP Code*

Section 7: Member or Legal representative's signature

I authorize the release of my PHI as identified above. I understand that this request does not apply to certain health information, including: (1) information that is not received or maintained by Optum, (2) psychotherapy notes, (3) information compiled in reasonable anticipation of or for litigation, and (4) other information not available for access under HIPAA.

Member or legal representative's signature ***Date*** *(MM/DD/YYYY)*