



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

If you need a **list of the prescriptions** you filled through OptumRx, you can view and print this information from your online account at [www.optumrx.com](http://www.optumrx.com) by logging in and selecting *Claims History* or by contacting customer service at the telephone number located on your health or pharmacy benefit plan ID card.

Complete this form to request a copy of your protected health information (PHI) **OptumRx Home Delivery Pharmacy** keeps and uses to provide pharmacy services to you. Under the Health Insurance Portability and Accountability Act of 1996 (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 you have questions about this form, call customer service at the telephone number located on your health or pharmacy benefit plan ID card. For assistance with healthcare information not managed by Optum, contact that entity directly.

OptumRx 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**

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**Return the completed form via**

**Fax: 888-371-7011**

**Mail: OptumRx Privacy Office, 2300 Main Street, MS: CA134-0304, Irvine, CA 92614**

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

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_  
*First Name Last Name Phone*

**Relationship to member**  Parent or legal guardian (describe relationship) \_\_\_\_\_  
 \*Someone else (describe relationship) \_\_\_\_\_

*\*Attach supporting documentation*

**Section 4: 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.

- Order History Summary**      \_\_\_\_\_  
*Order Number(s)*
- Order History Detail(s)**      \_\_\_\_\_  
*Order Number(s)*
- Copies of Prescriptions**      \_\_\_\_\_  
*Describe medication name(s), date(s), etc.*
- Billing Records**
- Other**      \_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_ *Start Date (MM/DD/YYYY)*

\_\_\_\_\_ *End Date (MM/DD/YYYY)*

**Section 5: 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 6: 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)*