



Request for an Accounting of Non-Routine Disclosures (Ask to Receive a List of Certain Disclosures)

Complete this form to ask for a list of disclosures of your protected health information (PHI) made regarding services provided by **OptumRx Home Delivery Pharmacy** for purposes outside of treatment, payment, or healthcare operations. We will report disclosures of your PHI made by us in the six years prior to the date of your request unless a Health Insurance Portability and Accountability Act of 1996 (HIPAA) exception applies. Exceptions include disclosures such as those made:

- To carry out treatment, payment, or health care operations,
- To you or someone legally authorized to act on your behalf,
- To anyone pursuant to an authorization form completed and signed by you or your authorized representative, or
- Incidental use or disclosure otherwise permitted or required by the HIPAA Privacy Rule.

Please complete each section below. Forms submitted with incomplete information, insufficient legal authority, or signed by the incorrect individual may be denied or 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 OptumRx, contact that entity directly.

Submitting a Request on Behalf of Another Individual

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 a request through this process**

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: Dates Requested

I would like a list of disclosures of my PHI made by OptumRx as described on the cover page for the following dates:

Start Date* (MM/DD/YYYY)

* Max six years prior to the date of request

End Date (MM/DD/YYYY)

Section 5: Select where to receive a response (Select only one option)

Send a response to the requestor (member or legal representative) in the following format:

Option 1: PDF sent by secure email to the address below (complete if different from Section 1)

Email Address

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

Address

City

State

ZIP Code

Section 6: Member or Legal representative's signature

I authorize the release of an accounting of disclosures of my PHI as indicated above.

Member or legal representative's signature

Date (MM/DD/YYYY)