Request for Access

(Get a Copy of Your Healthcare Information (Records))

Complete this form to request a copy of your protected health information (PHI) **OptumHealth Care Solutions** (branded as Optum) maintains and uses to make decisions about your benefits. 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 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.

OptumHealth Care Solutions ***(Wellness, Disease Management, Transplant, Bariatric, Infertility, etc.)***	☐ Summary of Claims Documentation ☐ Treatment Authorizations ☐ Call records/Nurseline call records	☐ Appeals/Complaints Information ☐ Clinical Management Documentation ☐ Other (specify below)
Physical Health ***(Chiropractic, physical therapy, and occupational therapy)***	☐ Summary of Claims Documentation ☐ Claims & Explanation of Benefits ☐ Clinical Submission Responses	☐ Appeals/Complaints Information ☐ Patient Summary Form ☐ 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)*