Optum

Request for a Restriction
(Ask to Limit Uses and Disclosures of Your Healthcare Information)

Complete this form to request that we limit certain uses and disclosures of your protected health information (PHI) related to **behavioral health** or **Employee Assistance Program (EAP)** services and benefits managed by Optum. Optum understands the importance of keeping your PHI confidential. We use and share information only as necessary to provide services to you and as permitted and required by law. We will consider all restriction requests but may not be able to honor your request if it will impact our ability to provide quality services to you.

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 plan ID card. For assistance with healthcare information not managed by Optum, 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: 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 ☐ Someone else (describe relationship) _____ ☐ Minor child

Preferred contact for questions:

( )	( )	
Home Phone	*Cell Phone*	*Email Address*

Section 2: Member who this request is being submitted for

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: Restriction Requested

Indicate how you would like Optum to restrict the ways we use and/or disclose your PHI and the reason(s) for your request. Please provide additional documentation supporting this request as needed.

Section 6: Select where to receive a response

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 7: Member or Legal representative's signature

I authorize the restriction of my PHI as identified above.

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