

Request for record of non-routine disclosures of Protected Health Information (PHI)

Complete this form to ask for a list of disclosures of your protected health information (PHI) made regarding services provided by Optum® Specialty 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.

If you have questions about this form, call us at the member telephone number located on your pharmacy materials. 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 an access request through this process**

Please note: We can only provide a report of non-routine disclosures made by Optum Specialty Pharmacy. To request information about routine or other non-routine disclosures not made by us, please contact your health or prescription benefit plan directly. Optum® Home Delivery, call **1-800-562-6223**. For Optum® Infusion Pharmacy, call **1-877-342-9352**. We will notify you if we are unable to respond to you within 60 days of receiving your request.

Mail the completed form to:

Optum Specialty Pharmacy, Privacy Office
2300 Main Street, Mail Stop: CA134-0304
Irvine, CA 92614

Fax: **1-888-371-7011**

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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.

I am submitting this request for: Myself Minor child Someone else

Describe your relationship to the member:

Preferred contact method: Home phone Mobile phone
 Email

1 Member information (please provide current information)

| | | |
|----------------------------|-----------------------------|--------|
| Last name | First name | MI |
| Mailing street address | | Apt. # |
| City | State | ZIP |
| Date of birth (mm/dd/yyyy) | Phone number with area code | |

2 Legal representative information (required if requestor is not the member)

| | | |
|------------------------|-----------------------------|--------|
| Last name | First name | MI |
| Mailing street address | | Apt. # |
| City | State | ZIP |
| Relationship to member | Phone number with area code | |

3 Date range of information requested

I would like this information for the following dates:

From (mm/dd/yyyy) to (mm/dd/yyyy)

Six years prior to the date of this request

Please note: Optum Specialty Pharmacy can provide a report covering a maximum of six years prior to the date we receive this request.

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4 Select where to receive a response

Send a response to me as indicated below (select one response):

Option 1: PDF sent via secure email to this email address:

Option 2: Paper copy sent by mail to the address below if different than Section 1

Mailing street address Apt. #
City State ZIP

Option 3: Other readily available electronic format

Please describe:

Mailing street address Apt. #
City State ZIP

5 Member or legal representative signature

I authorize the release of my PHI as identified above.

Member or legal representative signature Date

6 Please mail the completed form to:

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