Request to restrict use and disclosure of protected health information

The Health Insurance Portability and Accountability Act allows you to request that Optum limit certain uses and disclosures of your protected health information (PHI). For example, you may ask that we not share your PHI with a certain person. We will consider all restriction requests, but will only honor special requests or those required by law.

Optum understands the importance of keeping your health information confidential. We use and share only information that is necessary to provide services and as permitted and required by law. Sometimes, Optum is unable to honor requests to further limit how we use and/or disclose PHI because it would harm our ability to provide quality services.

If you pay fully out-of-pocket for an item or service and do not wish to disclose the transaction to your health plan for purposes of payment and health care operations, Optum will honor that request. To qualify, you must pay the full cost out-out-pocket for the transaction and make the non-disclosure request at the time of purchase, either in writing or verbally.

Optum will respond to requests submitted by your authorized representative, such as a parent, court-appointed representative or other family member, provided the representative is authorized by you to receive your PHI. However, we may ask for more information from you or your authorized representative to verify the right to act on your behalf. **Do not use this form to submit such a request because the transaction will have been completed by the time we receive your completed form.**

Your request to restrict PHI applies only to services provided by Optum. To obtain other PHI regarding services or benefits not provided by Optum, contact the company that provides those services or benefits.

If you have questions about this form, please call 1-800-777-3574 and speak with a customer service advocate.

Request to restrict use and disclosure of protected health information

Use this form to restrict how Optum uses and/or discloses your protected health information (PHI). When filling out this form, please complete all sections, print information clearly and provide your most current information. Once the decision to grant or deny your request has been made, you or your authorized representative will receive a letter notifying you of the decision.

1. Patient information

Last name | First name | Middle initial

Mailing street address | Apt. #

City | State | ZIP

Date of birth (mm/dd/yyyy) | ☐ M ☐ F Gender | Phone number with area code

2. Specific restriction requested

Please state how you would like Optum to restrict the ways we use and/or disclose your PHI and the reason(s) for your request.

3. Patient/authorized representative signature

Authorized signature of individual—or personal representative of individual—for whom the restriction is being requested:

Patient signature | Date

Authorized representative signature (if applicable) | Date

Important: If legal documentation is not on file with Optum, the authorized representative, including the parent, legal guardian, or executor of an estate, must attach a copy of legal documentation to this form.

Authorized representative's name | Phone number with area code

Mailing street address | Apt. #

City | State | ZIP

Relationship to patient and Authority to Act for Patient

4. Please mail the completed form to:

Optum, Attn: Medical Records PO Box 289, Huntingdon Valley, PA 19006

or email to OptumWC_recordsrequests@optum.com

Please keep a copy of this form for your records. You also have the right to receive a copy of this authorization.