Request for Access to Protected Health Information

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), you have a right to access and inspect the personal information that is maintained and used to make decisions about your benefits. HIPAA calls this your Protected Health Information (PHI) that is maintained in a Designated Record Set (DRS). This DRS includes enrollment information, claim requests for payment, claim payment, case or medical management records, appeals and/or complaint files, and other records that are used in whole or in part to make decisions about your benefits.

You can request information only about yourself, unless you are legally authorized to get information about another individual.

In an effort to make this information more understandable to you, we can provide you with a report that summarizes your eligibility, claims, and treatment authorization information. Please be aware that if you ask for this summary and if no claims have been processed for your treatment we may only be able to supply you with your eligibility records. If you request this eligibility, claims, and treatment authorization summary now, and later decide that you want supplemental information, you can request additional information at that time. If you need more detailed information now, you may request it.

When completing this form, please:

- Complete all sections entirely;
- Print information clearly;
- Provide us with your most current information.

Indicate the type of records you are requesting on the attached form, and the dates for which you want that information.

A reasonable, cost-based fee may be imposed for a copy of your PHI as permitted by the HIPAA Privacy Rule.

We will respond to requests from a personal representative authorized by a member to receive his or her PHI (e.g., parent, court appointed representative, family member).

Please note: If you are a guardian or court appointed representative for the individual, you must attach copies of your authorization to represent the individual in order to obtain access to his/her PHI.

Please note that entities will only supply you with PHI regarding benefits and programs they administer. If you are seeking information beyond your behavioral health and Employee Assistance Program (EAP) healthcare information covered by this form, you must contact each entity that administers your benefit directly. If we are unable to send you a copy of your PHI within 30 days from the date we receive your request, you will be contacted and advised about the delay.

This Request for Access to Protected Health Information form is for use by UnitedHealthcare and Optum members and their personal representatives. UnitedHealthcare behavioral health benefits are managed by Optum.

Request for Access to Protected Health Information

Use this form to request access to your PHI contained in a DRS relating to behavioral or EAP services. Complete this form in its entirety to ensure your PHI can be located and released. Once the request is approved, a copy of your PHI will be mailed to you or your authorized personal representative.

Section 1: PHI Requested For:

Name_____ Address_____

City_____ State _____ Zip _____Phone (_____)_____

Date of Birth _____ Male____ Female____

Relationship to Subscriber: Self_____ Spouse _____ Child_____ If other, describe type of relationship_____

Section 2: Subscriber Information

Subscriber Identification Number_____ Group Number_____ Employer_____

Subscriber Name_____ Address_____

City_____ State _____Zip_____ Phone (_____) - _____

Section 3: Type(s) of Information Requested

Please choose below the type of information you would like to receive:

- ☐ **Behavioral Health Information - mental health, substance abuse**
  - ☐ Claims Documentation
  - ☐ Treatment Authorizations (prior approvals to obtain services)
  - ☐ Clinical Management Notes
  - ☐ Appeals/Complaints Information
  - ☐ Other (please specify) _____
    _____

- ☐ **Employee Assistance Program (EAP) Information**
  - ☐ Claims Documentation
  - ☐ Treatment Authorizations (prior approvals to obtain services)
  - ☐ Employee Assistance Program (EAP) Notes
  - ☐ Other (please specify) _____
    _____

- ☐ **Life Solutions Information**
  - ☐ Clinical Management Notes
  - ☐ Assessments
  - ☐ Other (please specify) _____
    _____

- ☐ **Other (please describe)** _____
  _____

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Section 4: Date Range of Information Requested

I would like this information for the following dates:

- ❑ From _____ (MM/DD/YY) to _____(MM/DD/YY)

A reasonable, cost-based fee may be imposed for providing a copy of your PHI, as permitted by the Privacy Rule.

I authorize the release of my PHI to me at the address stated in Section 1 of this form. I understand that this request does not apply to certain health information, including: (1) information that is not received or maintained by my Insurance Company (2) psychotherapy notes (3) information compiled in reasonable anticipation of or for litigation; and (4) other information not available for access under HIPAA.

Signature of Individual: X _____Date_____

We will respond to requests from a personal representative authorized by a member to receive his or her PHI (e.g., parent, court appointed representative, family member).

Please note: If you are a guardian or court appointed representative for the individual, you must attach copies of your authorization to represent the individual in order to obtain access to his/her PHI.

Signature of Personal Representative if applicable: X _____ Date_____

Personal Representative's Name _____

Address_____

City_____ State _____Zip _____ Phone (_____) -_____

Relationship to individual and authority to act for individual:

_____

Please return the completed form to:

Fax: 888-371-7011

or

Mail to:

Privacy Administrator

MN101-E013

11000 Optum Circle

Eden Prairie, MN 55344