Request for an Accounting of Non-Routine Disclosures of Protected Health Information

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), you have the right to request an accounting of certain disclosures of Protected Health Information (PHI). PHI may be disclosed for treatment, payment, health care operations, and as required or permitted by the HIPAA Privacy Regulation or other state or federal laws. The Notice of Privacy Practices informs you that these disclosures may occur without your consent at the time they are made.

You can request an accounting of certain disclosures only about yourself, unless you are authorized to obtain information about another individual.

We are required to track and report to you upon request all disclosures of PHI made on or after April 14, 2003, except for disclosures made for the following reasons or to the following entities: (i) for treatment, payment, or health care operations; (ii) to you or someone legally authorized to act on your behalf; (iii) to anyone pursuant to an authorization form completed and signed by you or someone legally authorized to act on your behalf; (iv) or that are incidental to a use or disclosure otherwise permitted or required.

When completing this form please:

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

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 an accounting of non-routine disclosures 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 provide an accounting of non-routine disclosures to you within 60 days of receiving your request, we will contact you and advise you of the delay.

This Request for an Accounting of Non-Routine Disclosures of 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 an Accounting of Non-Routine Disclosures of Protected Health Information (PHI)

This form is used to request a report that lists the non-routine disclosures of your PHI. It must be completed in its entirety to ensure that your request can be accurately processed. Once the request is processed, a report will be mailed to you or your authorized personal representative. Please print.

Section 1: Accounting of Disclosures of PHI Requested For:

Member Name_____Address_____

City _____ State____ Zip_____ Phone Number (_____)_____

Date of Birth _____ Male ___ Female___

Relationship to Subscriber: Self____ Spouse ____Child____ If other, describe relationship_____

Section 2: Dates of this Request

Indicate the *date range* of the information you are requesting:

- ❑ From April 14, 2003 to the date of this request
- ❑ From (MM/DD/YY)_____to (MM/DD/YY) _____

Please note that we cannot provide you with information about disclosures before April 14, 2003.

Section 3: Signature of Member or His/Her Personal Representative

Authorized signature of individual, or personal representative of individual, about whom the PHI is being requested:

I authorize the release of an accounting of disclosures of my PHI to be sent to me; to others as directed in a signed authorization; or to others legally authorized to act on my behalf, at the address stated in Section 1 of this form. I understand that this request does not apply to certain types of disclosures, including for treatment, payment, or health care operations.

Signature of Individual: X _____ Date_____

Signature of Parent/Personal Representative (if applicable): X _____ Date_____

Parent/Representative's Name _____Address_____

City_____ State ____Zip _____Phone Number (_____)_____

Relationship to individual and authority to act for individual: _____

Important: A personal representative, including a parent, legal guardian, or executor of an estate, may be required to attach a copy of legal documentation to this request form.

Section 4: Subscriber Identification

Subscriber Identification Number_____Group Number_____ Employer_____

Subscriber Name_____Address_____

City_____State _____ Zip _____ Phone (_____)_____

Please return the completed form to:
Fax: 888-371-7011
or
Mail to:
Privacy Administrator
MN101-E013
11000 Optum Circle
Eden Prairie, MN 55344