Optum Frontier Therapies™

Request to amend Protected Health Information (PHI)

You have a right to change or amend personal information about you that Optum Frontier Therapies® keeps. The Health Insurance Portability and Accountability Act calls this protected health information (PHI). PHI includes order information and other records that we use to make decisions about the services you receive.

Use this form to request that Optum Frontier Therapies change or correct PHI we have about you that you believe is wrong or missing. For example, an order for a medication that was not prescribed to you, but is in our records. Optum Frontier Therapies may deny your amendment request if the PHI that is the subject of the request:

1. Was not created by Optum Frontier Therapies,
2. Is not part of the Optum Designated Record Set (DRS),
3. Would not be available for inspection (including, but not limited to, exempt items like psychotherapy notes and situations in which the PHI at issue is no longer maintained in the DRS), or
4. Is accurate and complete.

If you have questions about this form, call us at the telephone number located on your pharmacy materials. For assistance with healthcare information not managed by Optum Frontier Therapies, contact that entity directly.

This form should not be used to change your address, phone number or billing information associated with your account. You can update your contact information by contacting Optum Frontier Therapies at 1-855-768-9727

Submitting a request on behalf of another individual

Please have the **patient** 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**

Please note: We will amend only PHI relating to services provided by Optum Frontier Therapies.

Mail the completed form to:

Optum Frontier Therapies
6425 Santa Margarita Street, Unit 110
Las Vegas, NV 89118

Fax: **1-866-991-9929**

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Please complete each section below. Forms submitted with incomplete information, insufficient legal authority, or signed by the incorrect individual may result in processing delays.

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

Describe your relationship to the patient:

Preferred contact method: ☐ Home phone ☐ Mobile phone

☐ Email

1 Patient 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 patient)

Last name First name MI

Mailing street address Apt. #

City State ZIP

Relationship to patient Phone number with area code

3 Amendment requested

Please indicate what PHI you believe to be wrong and/or missing and describe the error. If the information relates to a prescription order, date of service, medication, etc., please include the order numbers, dates or other information that will help us process your request. Please attach a copy of the information you would like to amend.

If you need more space to explain your request, if you have a copy of the information you would like to amend, or if others need to be notified of any changes, provide additional supporting documentation.

If someone else also has this outdated information and should be notified if we make a change, please provide contact information below:

Last name First name MI

Relationship (e.g., Provider, Plan Sponsor, etc.)

Address City State ZIP

Phone number with area code

Last name First name MI

Relationship (e.g., Provider, Plan Sponsor, etc.)

Address City State ZIP

Phone number with area code

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4 Tell us where to send information

I would like this information provided to me as follows:

○ **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:

5 Patient or legal representative signature

I authorize the amendment and release of my PHI.

X Patient or legal representative signature Date

6 Please mail the completed form to:

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Las Vegas, NV 89118

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