Optum Frontier Therapies™

Request for access to Protected Health Information (PHI)

If you need a list of the prescriptions you filled through Optum Frontier Therapies®, simply call customer service at the telephone number located on your pharmacy materials and ask us to mail you a copy of your medication history report.

Complete this form to request a copy of your PHI that Optum Frontier Therapies keeps and uses to provide pharmacy services to you. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this is called the Designated Record Set (DRS).

Use this form to state the type of records you need and provide the date range for your request. Be as specific as possible. 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.

Optum Frontier Therapies may impose a reasonable, cost-based fee for a copy of your protected health information, as permitted by the Privacy Rule.

Requesting access to another individual's records

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 an access request through this process**

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

If we are unable to send a copy of your DRS within 30 days from the date we receive your request, we will let you know about the delay.

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 Type(s) of information requested

I would like to request the following type(s) of information (Check all that apply):
Some information, such as recordings of phone calls maintained for quality assurance purposes or PHI not used to make decisions about individuals, is not contained within the DRS and may not be provided.

☐ **Option 1:** A report that summarizes my order history from Optum Frontier Therapies

☐ **Option 2:** Prescription copy. Please describe:

☐ **Option 3:** Accounting statement

☐ **Option 4:** Other PHI. Please describe:

I would like this information for the following dates: start (mm/dd/yyyy) end (mm/dd/yyyy)

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4 Recipient and format of PHI

Recipient of PHI (select only one option)

○ Myself (patient)

○ Someone else:

Last name First name MI

Relationship

Format of PHI (how and where should we send the records)

○ **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 release of my PHI as identified above. I understand that this request does not apply to certain health information, including: (1) information that is not received or maintained by Optum Frontier Therapies, (2) psychotherapy notes, (3) information compiled in reasonable anticipation of or for litigation, and (4) other information not available for access under HIPAA.

X Patient or legal representative signature Date

6 Please mail the completed form to

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Las Vegas, NV 89118

Fax: 1-866-991-9929