

Request to restrict use and disclosure of Protected Health Information (PHI)

Complete this form to request that we limit certain uses and disclosures of your PHI related to services provided by Optum Frontier Therapies®. Optum Frontier Therapies understands the importance of keeping your PHI confidential. We use and share information only as necessary to provide services to you and as permitted and required by law. We will consider all restriction requests but may not be able to honor your request if it will impact our ability to provide quality services to you.

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 Frontier Therapies will honor that request. To qualify, you must pay the full cost out-of-pocket for the transaction and make the non-disclosure request at the time of purchase, either in writing or verbally. **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.**

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 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.

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: If your request is granted, the restriction will only apply to services administered by Optum Frontier Therapies. To restrict disclosures made by your health or prescription benefit plan, please contact them directly. For Optum Frontier Therapies call **1-855-768-9727**.

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

Preferred contact method: Home phone Mobile phone

1 Patient information (please provide current information)

2 Legal representative information (required if requestor is not the patient)

3 Specific restriction requested

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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 restriction of my PHI.

☒ Patient or legal representative signature

Date

6 Please mail the completed form to:

Optum Frontier Therapies

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