OPTUM®

REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act allows you to request that Optum® Specialty Pharmacy limit certain uses and disclosures of your protected health information (PHI). For example, you may ask that we not share your PHI with a certain person. We will consider all restriction requests, but will only honor special requests or those required by law.

Optum Specialty Pharmacy understands the importance of keeping your health information confidential. We use and share only information that is necessary to provide services to our clients' members and as permitted and required by law. Sometimes, Optum Specialty Pharmacy is unable to honor requests to further limit how we use and/or disclose PHI because it would harm our ability to provide quality services to our clients' members.

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 Specialty Pharmacy will honor that request. To qualify, you must pay the full cost out-out-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.

Optum Specialty Pharmacy will respond to requests submitted by your authorized representative, such as a parent, court-appointed representative or other family member, provided the representative is authorized by you to receive your PHI. However, we may ask for more information from you or your authorized representative to verify the right to act on your behalf.

Please note: If your request is granted, the restriction will only apply to services administered by Optum Specialty Pharmacy. To restrict disclosures made by your health or prescription benefit plan, please contact your plan directly.

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Use this form to restrict how Optum Specialty Pharmacy uses and/or discloses your protected health information (PHI). When filling out this form, please complete all sections, print information clearly and provide your most current information. Once the decision to grant or deny your request has been made, you or your authorized representative will receive a letter notifying you of the decision.

1 Member information (please provide current information)

Last Name | First Name | MI

Mailing Street Address | Apt. #

City | State | ZIP

Date of Birth (mm/dd/yyyy) | Gender ☐ M ☐ F | Phone Number with Area Code

2 Specific restriction requested

Please state how you would like Optum Specialty Pharmacy to restrict the ways we use and/or disclose your PHI and the reason(s) for your request.

3 Member/authorized representative signature

Authorized signature of individual—or personal representative of individual—for whom the restriction is being requested:

X _____ _____
Member Signature | Date

X _____ _____
Authorized Representative Signature (if applicable) | Date

Important: If legal documentation is not on file with Optum Specialty Pharmacy, the authorized representative, including the parent, legal guardian, or executor of an estate, must attach a copy of legal documentation to this form.

Authorized Representative's Name | Phone Number with Area Code

Mailing Street Address | Apt. #

City | State | ZIP

Relationship to Member and Authority to Act for Member

4 Please mail the completed form to: Optum Specialty Pharmacy, Privacy Office, 2300 Main Street, Mail Stop: CA134-0304, Irvine, CA 92614