Request to amend protected health information

You have a right to change or amend personal information about you that Optum 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 change or correct information we have about you that you believe is wrong or inaccurate.

You can only request to correct or update your own PHI, unless you are authorized to amend information about someone else.

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

Your request to amend PHI applies only to services provided by Optum. To amend other PHI for services or benefits not provided by Optum, contact the company that provides those services or benefits.

If you have questions about this form, please call 1-800-777-3574 and speak with a customer service advocate.

Request to amend protected health information

Use this form to amend or change protected health information (PHI) maintained by Optum. When filling out this form, please complete all sections, print information clearly, provide your most current information and state what information we have about you that you believe to be wrong/incomplete and want to correct. Once we make a decision about your request, we will send you or your authorized representative a letter explaining the decision.

1. Patient information

Last name | First name | Middle initial

Mailing street address | Apt. #

City | State | ZIP

Date of birth (mm/dd/yyyy) | ☐ M ☐ F Gender | Phone number with area code

Date of injury (mm/dd/yyyy)

2. Amendment requested

Please indicate what PHI you believe to be inaccurate and/or incomplete and describe the error. Please attach a copy of the information you would like to amend.

If someone else also has this outdated information and should be notified if we make a change, please provide contact information below:

Name | Relationship (Provider, plan sponsor, etc.)

Mailing street address | Apt. #

City | State | ZIP

Name | Relationship (Provider, plan sponsor, etc.)

Mailing street address | Apt. #

City | State | ZIP

3. Patient/authorized representative signature

I authorize the amendment of the stated protected health information for others as directed in a signed authorization; or to others legally authorized to act on my behalf, to request an amendment of the stated PHI.

Patient signature | Date

Authorized representative signature (if applicable) | Date

Important: If legal documentation is not on file with Optum, 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 patient and Authority to Act for patient

4. Please mail the completed form to:

Optum, Attn: Medical Records 175 Kelsey Lane, Tampa, FL 33619

or fax to: 1-888-579-0064

Please keep a copy of this form for your records. You also have the right to receive a copy of this authorization.