Plan Member Request to Access Protected Health Information

Member Name (PLEASE PRINT): ________________________________SSN: ____________

Mailing Address: Street ____

City ____________________________ State _______ Zip __________

Complete This Section

I request access to Protected Health Information (PHI) held about me in the group health plan's (the Plan) "designated record set" in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). A "designated record set" is (1) a group of records maintained by or for the Plan including enrollment, payment, claims adjudication and health plan case or medical management record systems or (2) records used by or for the Plan to make decisions about individuals. The term "record" means any item, collection or grouping of information that includes protected health information that is maintained, collected, used or disseminated by or for the Plan.

- If my request is granted, please send the copy of my PHI to the following address:

Street ____

City ________________________________ State ________________ Zip ______________

I request that the information be provided in the following format (check only one:)

Hard Copy (Paper) ______ Computer Disk ______ CD Rom ______ Email ______

I understand that if the format requested is not readily producible, the Plan will provide a hard (paper) copy.

Important Information About Your Request

I understand that I will not be provided access to certain health information, including: (1) information that is not held in the designated record set, which is defined below; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and (4) other health information not subject to the right to access information under HIPAA.

I understand that, because most of the information is off-site, the Plan has 60 days to respond to this request. If the Plan is unable to take action within that 60-day time period, the Plan may extend the time by 30 days. Within the initial 60-day time period, the Plan will mail me a written statement of the reasons for the delay and the date by which the Plan will complete its action on the request.

I understand that if the Plan grants this request, in whole or in part, it will inform me of the acceptance of this request and provide the information. If the Plan denies the request, in whole or in part, it will provide me with a written denial.

I understand that if the same PHI that is the subject of this request is maintained in more than one designated record set or at more than one location, the Plan will only produce the protected health information once in response to my request.

Date ________ Signature ____

PLEASE MAIL TO:

Benefit Services Manager

Department of Human Resources Services

Benefit Services Division

2033 K Street, NW, Suite 220

Washington, DC 20052

For Plan Use Only: Date Request Received __________________

By: ____