REQUEST TO INSPECT OR COPY PROTECTED HEALTH INFORMATION

"The Employer"			
"The Plan(s)"			
Employee			
Address			
City/State/Zip			
Email			
Last 4 Numbers of Employee's Social Security Number		Employee's Birthdate (Month & Day) MM/DD	
Individual's Name			
Check One	_____ I am the individual.		
	_____ I am an authorized representative of the Individual.		
IF YOU ARE NOT THE INDIVIDUAL, WHAT IS YOUR REASON AND AUTHORITY TO MAKE THIS REQUEST?			

I hereby request to review protected health information (PHI) about me in a "designated record set" held by the Plan in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). *"A "designated record set" is a group of records maintained by or for the Plan including enrollment, payment, claims adjudication and health plan case or medical management records; or 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 PHI that is maintained, collected, used or disseminated by or for the Plan."*

I understand that the Plan has 30 days to respond to this request, or, if someone else holds the information or if the information is off-site, the Plan has 60 days to respond. If the Plan is unable to respond within the 60-day period, the Plan may extend the response period by 30 days, provided that the Plan provides me a written statement of the reasons for the delay and the date by which the Plan will respond to the request. I understand that if the Plan grants this request, in whole or in part, it will inform me of the acceptance and provide the information requested or arrange for a convenient time and place to inspect or copy the PHI. If however the Plan denies this request, in whole or in part, it will notify me in writing. I understand that this request does not apply to certain health information, including (1) information that is not held in the designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for the use in, a civil, criminal or administrative action or proceeding; and (4) other health information not subject to the right to access of information under HIPAA. I agree to pay any fees for copying, summarizing, or explaining my health information. Fees will be reasonable and cost based and will include only the costs of copying, postage and/or preparation of a summary as needed to accommodate my request.

Check all that apply to your request:		I want to inspect the PHI about myself in the designated record set.
		I want to obtain a written copy of the PHI about myself in the designated record set.
		I want to obtain an electronic copy of the PHI about myself in the designated record set, if this option is available.
		I agree that the Plan may provide a summary of the PHI instead of allowing me to review the information.

Signed by: _____ Date Signed: _____

EMPLOYER/PLAN USE ONLY: