REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

This form must be filled out completely.

_____	_____	_____
Member Name	Member ID or DOB	Phone number

I am requesting a copy of the following information (you must mark a selection):

- ☐ Care coordination/treatment
- ☐ Clinical appeal documentation
- ☐ Grievance and/or appeal representation
- ☐ Claims information
- ☐ Other _____

I would like information from the following time periods:

- ☐ Other _____

Please send the information to me:

- ☐ On paper to my address: _____
- ☐ Electronically to my email: _____

Please provide a copy of your identification or driver's license.

_____ _____
Signature of the member or personal representative Date

_____ _____
Print the name of the member's personal representative Date

_____
Description of personal representative's authority

Personal Representatives: If you are signing this authorization on behalf of a member, you must include documentation that supports your authority to make health care decisions on behalf of the member.

Minors: Minors 15 years and older may authorize the release of mental health information by signing this form. Minors of any age may authorize the release of health care information related to the treatment of sexually transmitted diseases, including HIV/AIDS, alcohol and/or drug abuse treatment, contraception treatment, and prenatal care services by signing this form.

If you need this document in large print, Braille, other formats, or languages, or read aloud, or need another copy, call 800-511-5010. For TDD/TTY, call 888-803-4494. Call Monday to Friday, 8 a.m. to 5 p.m. The call is free.

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