

MEDICAL RECORDS REQUEST FOR MEMBER

This form must be filled out completely.

Member name

Member ID or date of birth

Phone number

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

- Care coordination/treatment
- Clinical appeal documentation
- Enhanced Standardized Assessment (ESA)
- 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.

Si necesita este documento en letra grande, Braille, otros formatos o idiomas, o se lea en voz alta, o necesita otra copia, llame al 800-511-5010. Para TDD/TTY, llame al 888-803-4494. Llame de lunes a viernes, de 8 a.m. a 5 p.m. La llamada es gratis.