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# ACCESS REQUEST

Purpose: This form is used for an individual's request to inspect and/or obtain copies of an individual's protected health information contained in our designated record set, or the designated record set of our business associates.

**SECTION A: Individual's information being requested.**

Name: ______________________________________________

Address: ______________________________________________

City: ______________________ State: ______________ Zip: ___________

Member Identification Number: ___________ Birth Date: ____________________

**SECTION B: To the Individual—Please read the following and complete the information requested.**

You have the right to inspect and obtain a copy of your protected health information in a designated record set that our business associates or we maintain. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes we may have, any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other information. To exercise your right of access, please complete the information below:

Please specify the information you wish to inspect or obtain copies of:

**Claims Information:** Dates of service from: __________to:______________________

Confined to the following condition or provider____________________

**Enrollment Information:** For the period from:______________ to:________________

Specific to: ____________________________________

**Other Information:** For the period from:________________ to:________________

Specific to: ____________________________________

**Please note**: The records we will provide to you pursuant to this request will pertain to your current health benefits. If you wish to access information relating to a previous coverage (for example coverage through a former employer or under a previous contract), you must submit an additional Access Request form for each former coverage about which you are seeking information. You must identify the former coverage about which you are seeking information.

Do you wish to: Inspect this information or obtain copies? __________________________

Do you want us to mail the copies? _____ (We reserve the right to charge $0.75 per page to copy this information, and for the cost of postage, if mailed. If we choose to charge a fee, you will be notified and payment in the form of a certified check or money order is expected in advance of mailing.)

Individual's Signature: ______________________Date: _______________

If this request is from a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name *(please print)* :__________________ Date: _________

Relationship to Individual: ____________________

Version Date: 03/07/03

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***PLEASE TAKE A COPY OF THIS FORM FOR YOUR RECORDS.***

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