



Individual Request for Access to PHI

As a member of The Health Plan, you have a right to access, inspect and obtain a copy of your health information contained in a designated record set.

The Health Plan will act on this request within 30 days of the date this form. We will let you know in writing if we are not able to provide the requested information within this time frame. We will also let you know in writing if we deny your request for access including the reason for the denial.

Please indicate specifically the information to which you are requesting access. We can provide you with a summary of the requested information in lieu of access. Just let us know.

Please indicate the form or format in which you would like to receive your requested information. If you request a form or format that is not readily available, we will contact you to determine an agreeable format.

Please indicate the means by which you wish to inspect or obtain a copy of the requested information (fax, mail, on-site, etc.), and provide the necessary numbers or address. If you want us to send the information to someone else, include that information below.

Please note that if you request a copy by email, we cannot guarantee the security of the email transmission.

Name (printed): _____

Today's date: _____

Signature: _____

FOR THP USE ONLY:

Date request received by The Health Plan: ____/____/____

Date information sent to the member: ____/____/____

How was the information sent: _____

Date of extension letter sent (if applicable): ____/____/____

Date denial notice sent (if applicable): ____/____/____

Completed form should be uploaded into the member record