PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

AFN: HIP-006 (12/2022)

Participant Name: **Participant ID #:**

I hereby request Public Safety/Corp Cancer Insurance Policy Program to allow me to inspect and/or obtain a copy of the following records:

Description of records to be inspected/copied:

And I understand that I can inspect my records free of charge. However, if I wish to obtain copies of the records or have the copies mailed to me, there is a nominal fee associated with the request which is:

Calculated fee for copying: **Calculated fee for mailing:**

The fee covers the cost of copying and mailing the aforementioned records. I also understand that I may be required to pay the fee in full before I can obtain the copies. The aforementioned records can be mailed to me at the following address:

Address1: **Home Phone:**

Address2: **Work Phone:**

City, State, Zip:

I further understand that:

1) All health benefit plans and some of their vendors, including Public Safety/Corp Cancer Insurance Policy Program, maintain certain protected health information about me as a participant, such as claims records, and records that are used, in whole or in part, to make decisions about me, my treatment, or payment for services.
2) I have the right to inspect and obtain a copy of my above mentioned protected health information maintained by Public Safety/Corp Cancer Insurance Policy Program.
3) My request must be made in writing using this form, which must be completed prior to Public Safety/Corp Cancer Insurance Policy Program providing me with the requested information.
4) If I request Public Safety/Corp Cancer Insurance Policy Program to copy and mail the requested information, they have the right to charge me for copying and mailing the requested information to me.
5) I have the right to request an amendment to my protected health information mentioned above.
6) Within 30 days (60 days if information is not maintained or accessible on-site), I will receive a response from Public Safety/Corp Cancer Insurance Policy Program indicating whether my request for access has been accepted or denied, or a notification that an additional 30 days is required to consider my request. If an extension is required, I will be given an explanation of the reason for the delay and the date by which a decision will be made. If my request is denied, I will be informed in writing of the reason for the denial, and given instructions on how I can go about disputing a denial or filing a complaint.

OR

Participant: Your 'Typed' First and Last Name Constitutes Your Signature

Name of Participant's Representative (*if applicable*) Your 'Typed' First and Last Name Constitutes Your Signature

Relationship: (proper documention must be included)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

Date *(MM DD YYYY format)*

Submit Form

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**** For Office Use Only ****

ID Verification Completed By:

Date Verification Completed:

(MM DD YYYY format)

Notes:

Request **Accepted** ☐ **Denied** ☐

Reason for Denial (*if applicable*)

- ☐ Access is likely to endanger the life or physical safety of the individual or another person
- ☐ Psychotherapy notes
- ☐ The information is compiled for use in a civil, criminal, or administrative action or proceeding
- ☐ Other (*full list of other reasons for possible denial at 45 CFR §164.524(a) (1)-(3)*):

Date Request Received **Received By**

Date Request Fulfilled **Fulfilled By**

Extension Requested ☐ **Yes** ☐ **No**

Date Participant Notified in Writing of Extension

If Extension Requested, Give Reason