«first_name» «last_name»
«address1» «address2»
«city», «state» «zipcode»

Your Right to Access Protected Health Information (PHI)

What does the right to access PHI mean?

You or someone else you choose have the right to inspect, review or get a copy of the PHI. It's kept by Providence Health Plan in the designated record set per the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The designated record set is a group of records maintained by or for your plan. It includes certain records used to make decisions about you as a member. This set may include records regarding:

- Enrollment
- Claims
- Case management
- Medical management
- Utilization management

What do I need to know to use this right?

- Your access to your records may have legal limits. This could relate to records not accessible under HIPAA.
- You do not have a right to access PHI that is not part of the designated record set.
- You may not be allowed to receive all PHI. For example, you won't receive psychotherapy notes or data compiled for likely use in a civil, criminal, or official action or proceeding.
- Calls are recorded for quality and training purposes only. Providence Health Assurance (PHA) is not required to transcribe or produce a recorded call.
- PHA will make every effort to produce records in the format you asked for. However, if PHA cannot quickly produce records in the format you want, we'll agree together on an alternate format.
- ***For copies of your medical records, call your provider's office.***
- **Appeals and Grievances:** you may request a copy of the documents collected/created by PHA to respond to an appeal or grievance. It's free. Just call Customer Service at the toll free number listed on your PHA HealthCare ID card.
- If you want to release sensitive documents to a minor, federal and state laws may prevent PHA from granting your request. You'll need written approval from the minor member to release those documents.

How much will this cost me?

- The hard copies you asked for will be free.
- The electronic (email) copies you asked for will be free.
- If you wish to pick up or view on site, it will be free.

- If you wish to have records on a CD, it will cost a flat fee of $6.50.

How will I know if my request is processed?

PHA will respond to this request within 30 days. If we cannot respond within 30 days, we'll send you a written notice about why it will take longer. It will show the date by which we'll fulfill your request. In certain cases, PHA may deny your request. If we deny your request, we'll tell you in writing and let you know if and how you can appeal our decision.

How do I ask for access?

Here is the Request to Access Protected Health Information (PHI) you asked for. Please complete the entire form, sign it and return it to Providence Health Assurance at:

Providence Health Assurance
P.O. Box 4327
Portland, OR 97208-4327

You may fax your Request to Access form to 503-574-8608. Or you may hand deliver it (if mailing, use only the post office box address listed above) to the following address:

Providence Health Assurance
Attn: Customer Service
3601 SW Murray Blvd. #10
Beaverton, Oregon 97005-2359

If you have any questions, need this in large print, braille or a different language, please call us Monday through Friday, 8 a.m. to 5 p.m., at 800-898-8174 (TTY:711).

Sincerely,

Providence Health Assurance
Enclosure

Request to Access Protected Health Information (PHI)

Use this form to request a copy of your PHI in a Designated Record Set that PHA or one of its business associates maintains. If you need help completing the form, please contact the PHA Customer Service number listed on your member ID card. You must complete all the fields on this form.

PART A: MEMBER DETAILS		
Member Last Name	**Member First Name**	**Middle Initial**
Member Date of Birth	**Member Identification Number (See your member ID card)**	**Group Number (See your member ID card)**
Member Street Address	**City and State**	**ZIP Code**

PART B: HOW TO REQUEST DATA

I request PHI about me in a designated record set held by PHA. By placing, an "X" in the correct box below, please indicate who will receive your data. Send my PHI to: (**select only one**)

☐ Me at the address listed above (If email is selected below in PART C, PHA will not mail to the address above.)

☐ I request that Providence Health Assurance send my PHI, as specified in Part D, to the chosen third party listed below.

Name	**Address**	
City and State	**Zip Code**	**Phone Number**

PART C: HOW TO RECEIVE DATA

By placing an "X" in the correct box below, please indicate how you wish to receive/review your data. Send my PHI: (**select only one**)

☐ Send paper copies of my records, shown below in Part D, via US certified mail.

☐ Send electronic copy of my records, shown below in Part D, via email. Note: Data will be sent to the email address provided below by secure email unless otherwise described.

Email address: ____

If you prefer the e-mail be sent unsecured, please initial here: _________

☐ Send electronic copy of my records, shown below in Part D, via a CD. Note: CD will be sent to the address provided above (secured) unless otherwise described.

If you prefer the CD be sent unsecured, please initial here:_________

(Warning: Some level of risk may occur by sending your PHI via unsecure emails or CDs. They could be read by people who should not have access.)

☐ I want to pick up my records, identified below in Part D, in person, during regular business hours at the PHA office. I understand that I or my chosen backup will be contacted to arrange for this.

☐ I want to view in person. I understand that I or my chosen backup will be contacted to arrange for this.

PART D: DETAILS OF PHI REQUEST

I request the PHI contained in the following records. Please place an "X" next to the items you're requesting.

☐ **Enrollment & Eligibility Information**

Date(s) of Enrollment: ____

Details of request: ____

☐ **Claims Information, including Pharmacy (Summary of claims paid or denied)**
(This does not include details on claims received but not yet processed. If you'd like the status of those claims, you may call Customer Service at the toll-free number listed on your PHA HealthCare ID card.)

Date(s) of Service: ____

Provider(s):____

Details of Request:____

☐ **Case or Medical or Utilization Management Information (Prior Authorization)**

Date(s) of Service: ____

Provider(s):____

Details of Request: ____

☐ **Customer Service Inquiry (CSI)**

Date(s) of Call: ____

Details of Request: ____

☐ **Mental Health (Summary of claims paid or denied)**
(If you check this box, please initial mental health below)

Date(s) of Service: ____

Provider(s):____

Details of Request: ____

I consent to the release of the following sensitive data if it's part of my record. This data will only be released if I place my initials in the correct space next to it. *I understand that my alcohol/substance abuse records are protected under federal and state privacy laws and regulations. These records cannot be released without my written consent unless the laws and regulations allow it.

(Initial all that apply):

_______AIDS or HIV

_______Alcohol/Drug/Substance Abuse (Diagnosis, treatment or referral data) *

_______Genetic Data (services or tests)

_______Maternity/Pregnancy

_______Mental Health Data and Records

_______Sexually transmitted illness/disease (testing and treatment)

☐ **Other Information**

Date(s) of Service: ____

Provider(s):____

Details of Request: ____

PART E: MEMBER SIGNATURE AND DATE

By:____ **Date:_______________**

(Member Signature)

- OR –

By:____ **Date:_______________**
(Member's Chosen Legal Delegate/Guardian Signature)

Relationship to member: ☐ Parent ☐ Legal guardian* ☐ Holder of Power of Attorney*

***If this form is signed by someone other than the member or Parent, please attach legal proof if you you're the legal guardian or Holder of Power of Attorney.**

- *Note to parents/legal guardians of minors: state laws may prevent PHA from allowing sensitive details to be released without the minor member's written approval. (Both parent and minor must sign.)*

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a member who needs these services, please call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, you can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

[illegible] 1-800-878-4445 (TTY: 711)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما ف می باشد. با (TTY: 711) 1-800-878-4445 تماس بگیرید.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)