

**REQUEST FOR ACCESS TO  
HEALTH INFORMATION**

*Our Members and their personal or legal representatives have the right to inspect and obtain a copy of most information in our records that may be used to make decisions about them for as long as we maintain the information in our records. Members and their personal or legal representatives may also request that we provide a summary of the information (instead of copies) or an explanation of complicated information. Please see our Notice of Privacy Practices for a more detailed description of these rights and the process we follow once we have received a request. To request access to records, please complete and return the following request form.*

**SECTION A: Member Information** (Please Print)

Member's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Member Identification Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone number where we can reach you to process your request (required) : (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address (optional): \_\_\_\_\_

**SECTION B: Recipient Information** (Who do you want the information shared with?)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number where we can reach you to process your request (required) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address (optional): \_\_\_\_\_

**SECTION C: Access Requested** (What information would you like to access and please provide the relevant date ranges.)

*You may attach a separate page if more space is needed.*

**SECTION D: Access Type** (Check all that apply)

**What type of access are you requesting?**

INSPECT \_\_\_ COPY \_\_\_ SUMMARY \_\_\_ EXPLANATION \_\_\_

*\*\*\*If your request to inspect the information is granted, we will provide you with further information on how to schedule an appointment with our staff to inspect your records.*

**If you are requesting a copy, summary, or explanation of the information, how would you like these materials copied?**

\_\_\_ Hard Copy                      \_\_\_ Electronic Format (if information maintained electronically)

*\*\*\* Note that some requests for copies in Electronic Format may result in copies being provided in a combination of Electronic Format and in Hard Copy as some records requested may not be maintained electronically.*

**If you are requesting a copy, how would you like the copies provided and delivered?**

*Hard Copy Requests:*

\_\_\_ PICK UP

\_\_\_ BY MAIL

*Electronic Format Copy Requests:*

\_\_\_ BY EMAIL [Email address required: \_\_\_\_\_]

\_\_\_ OTHER

**\*\*\* If your request is being made because of an emergency, please describe the nature of the emergency and the date you need the information. We cannot guarantee that we will meet your deadline, but we will do our very best to accommodate reasonable requests.**

**SECTION E. Fees**

**Copying and Distribution Costs.** We will charge you a reasonable fee to recover the costs of copying. Our standard fee for copying is \$.75 per page. [For electronic media, we will charge you a fee of [\$\_\_\_\_\_] for each compact disc provided or [\$\_\_\_\_\_] for a USB flash drive.]

**SECTION F. Expiration of Authorization**

This permission to share your protected health information with a person or organization will end on the earlier of your last day as a plan member, or when you write to us and tell us to end it. You can tell us to stop sharing the information in the future, however, it's not possible to "take back" the information we've already shared per your request.

|   |                        |
|---|------------------------|
| <b>SECTION G. Understanding and Signature</b>   |                        |
| By signing below, I am requesting that CareConnect Insurance Company, Inc. provide me with access to health information in the manner described above. I understand my records may have information about specific medical care or services I sought or received. The information may include medical, claim or benefit records. I will be expected to pay the fees for a summary or explanation or an expedited request. |                        |
| <b>Member Signature</b>   |                        |
| X _____<br>(Signature)  | Date: _____            |
| <b>Legal Guardian/Representative Signature</b>  |                        |
| <i>Please note: If you are a legal guardian or representative for the member, you must attach copies of your legal authorization as required by state law to represent the member – for example, power of attorney, healthcare proxy or guardianship papers.</i>  |                        |
| X _____<br>(Signature)  | Name: _____<br>(Print) |
| Relationship to Individual: _____   | Date: _____            |

**Please Return this Completed Form via Mail or Fax:**

**Mail to:**

CareConnect Insurance Company, Inc.  
 Attention: Privacy Officer  
 2200 Northern Boulevard, Suite 104, East Hills, NY 11548

or

**Fax to:** (516) 706-3829

**PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS**

|   |
|---|
| <b>For Internal Use Only:</b>   |
| Date Received: (MO/DY/YR) ____/____/____  |
| Disposition of Request: ____ GRANTED ____ DENIED ____ PARTIALLY DENIED                    |
| Member Notified in Writing of Response to Request on This Date: (MO/DY/YR) ____/____/____ |
| Fee Charged for Fulfilling This Request (if applicable): \$ _____                         |
| Name or initials of Privacy Officer: _____  |