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.)

I authorize the following information to be used or disclosed by CareConnect Insurance Company, Inc. on my behalf:
Describe:

Start Date_____ **(MM/DD/YEAR)** **End Date**_____**(MM/DD/YEAR)**

I also authorize the use or release of the following types of sensitive information by CareConnect Insurance Company, Inc. *(please select all that apply):*

___ **Mental Health Related Information** ___ **HIV/AIDS-Related Information**

___ **Alcohol/Drug Treatment Information** ___ **Genetic Information**

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.*

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 cost-based fee to recover the costs of copying and will notify you in advance of the approximate cost. [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.

SECTION G. Understanding and Signature

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.

Member Signature

X _____ Date: _____
(Signature)

Legal Guardian/Representative Signature

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.*

X _____ Name:_____
(Signature) (Print)

Relationship to Individual: _____ Date: _____

Please Return This Completed Form To:

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

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS

For Internal Use Only:

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: _____