Providence Health Assurance

MEMBER ACCESS TO RECORDS FORM

Complete this form to request a copy of your health information (claims, enrollment/eligibility, prior authorization) from Providence Health Assurance (PHA). This request only applies to health plan records held by PHA; contact your provider's office for your non-health plan medical records. Please use your member identification (ID) card to help you complete the information in Part A.

PART A: MEMBER INFORMATION *(Provide your name and personal information)*

Member Last Name	Member First Name	Middle Initial
Member Date of Birth	Member Identification Number (see your ID card)	Group Number (see your ID card)
Member Home/Street Address	City, State, and Zip Code	Preferred Phone Number

PART B: SELECT WHERE TO SEND YOUR INFORMATION

☐ Paper copy to the above mailing address in Part A

☐ Paper copy to the third-party listed below:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

☐ Electronic copy emailed to: _____
(Email address)

Information will be sent via secure (encrypted) email unless otherwise specified. Initial if you wish email to be sent unencrypted: _____.

Note, some level of risk is associated with sending your health information via unencrypted email or by mail, as your records could be accessed by an unauthorized third party.

PART C: SELECT WHICH RECORDS YOU ARE REQUESTING

☐ **Enrollment and Eligibility Information**

Date(s) of enrollment: _____

Details of request:

☐ **Claims information, including Pharmacy**

(Summary of claims paid or denied. Does not include information on claims received but not yet processed. If you would like the status of those claims, contact Customer Service.)

Date(s) of service: _____

Provider(s): _____

Details of request: _____

☐ **Mental Health Claims**

**** Must initial "Mental Health" in PART D ↓ or information will NOT be included ****

Date(s) of enrollment: _____

Provider(s): _____

Details of request:

☐ **Case Management/Medical Management/Utilization Management (Prior Authorizations)**

Date(s) of service: _____

Provider(s): _____

Details of request: _____

☐ **Customer Service Inquiry (CSI)**

Date(s) of service: _____

Details of request:

☐ **Other Information (Specify)**

Date(s) of service: _____

Provider(s): _____

Details of request: _____

PART D: SENSITIVE INFORMATION THAT CAN BE DISCLOSED BY PHA *(Write your initials (not X or ✓) on the line next to each type of sensitive information you wish to include)*

If our records contain any of the types of information listed below, additional laws relating to the use and disclosure of the information may apply.

***I understand that certain types of sensitive information, including some that are related to alcohol/substance use, are protected under Federal and State privacy laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I understand and agree that the below information will only be disclosed if I **write my initials** on the line next to the specified sensitive information.*

_____ *(Initial)* HIV (testing and treatment)	_____ *(Initial)* Mental Health Data and Records
_____ *(Initial)* *Alcohol/Drug/Substance Use (diagnosis, treatment, referral information)	_____ *(Initial)* Maternity/Pregnancy (reproductive health)
_____ *(Initial)* Genetic Information (services or tests)	_____ *(Initial)* Sexually Transmitted Illness/ Disease (testing and treatment)

Please note: To parents/legal guardians of minors, some state laws may prohibit PHA from acting on your request about Sensitive Information without written authorization from the minor member.

_____ *Minor Member's Signature*		_____ *Date*

PART E: MEMBER SIGNATURE AND DATE *(Sign your name and write the date below)*

_____ *Member's Signature* _____ *Date*

_____ *Member's Designated Legal Representative/Guardian Signature* _____ *Date*

Relationship to Member: ☐ *Parent of a Minor* ☐ **Legal Guardian* ☐ **Power of Attorney*

**If this form is signed by someone other than the member, please attach authorizing legal documentation of guardianship or power of attorney.*

PART F: RETURN THE COMPLETED FORM TO PHA		
Mail:	**Fax:**	Email:
Providence Health Assurance Attn: CBI PO Box 4327 Portland, Oregon 97208-4327	503-574-8608	DRSRequest@providence.org
If you have any questions, please call Providence Medicare Advantage Plans at 503-574-8000 or 1-800-603-2340. TTY users should call 711. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time). Between April 1st and September 30th we are closed Saturdays and Sundays.		

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Information about Your Request to Access Your Protected Health Information (PHI)

What does my right to access my health information mean?
You or your personal representative have the right to receive a copy of your health information, also known as protected health information, kept and maintained by Providence Health Assurance in a designated record set (DRS) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The designated record set is a group of records maintained and used by or for Providence Health Assurance, to make decisions about you as a member. The DRS may include records related to enrollment, claims, case management, medical management, or utilization management.

What do I need to understand to use this right?
- You may request copies of your health information kept and maintained by PHA.
- PHA will follow the timelines required by HIPAA and/or applicable state law which may require a more expedited response time. If we are unable to respond within the required timeframe, we will send you a written explanation for the delay. This request only applies to records held by PHA. If you need medical records from your provider, you will need to contact their office directly and make a separate request.
- You may not be able to access all records, for example, certain records used in legal or administrative proceedings.
- Customer service calls are recorded for training and quality purposes. PHA is not required to transcribe or share call recordings.
- Appeals and Grievances: You may request a copy of the documentation created by PHA to respond to an appeal or grievance. Call Customer Service at the number on your PHA ID card.

How much will this cost me?
- There is no charge for your records.