

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

What does the right to access PHI mean?

You or your personal representative have the right to inspect, review or get a copy of the information kept by Providence Health Plan in the designated record set in accordance with 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, including certain records used to make decisions about you as a member. This set may include records pertaining to enrollment, claims, case management, medical management, or utilization management.

What do I need to understand to use this right?

- Your access to your records may have legal limits, such as in relation to health information not subject to the right to access information under HIPAA.
- You do not have a right to access PHI that is not part of the designated record set.
- You may not be entitled to receive all of your PHI. For example, you will not receive information such as psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.
- Calls are recorded for quality and training purposes only. Providence Health Plan (PHP) is not required to transcribe or produce a recorded call.
- PHP will take reasonable efforts to produce the designated record in the format you have requested. However, if PHP cannot readily produce the records in the format requested, a mutually agreeable alternative will be established.
- ***For copies of your medical records, call your provider's office.***
- **Appeals and Grievances:** you may request a copy of the documentation collected/created by PHP to respond to an appeal or grievance, free of charge by calling Customer Service at the toll free number listed on your PHP HealthCare ID card.
- If you are requesting the access for a minor, federal and state laws may prohibit PHP from acting upon any request for information relating to sensitive services unless written authorization is received from the minor member.

How much will this cost me?

- The hard copies you are requesting will cost a flat fee of \$10.00.
- The electronic (email) copies you are requesting 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?

Providence Health Plan will respond to this request within 30 days. If we cannot respond within 30 days, we will send you a written notice describing why it will take longer and the date by which your request will be fulfilled. In certain cases, Providence Health Plan may deny your request. If we deny your request, we will tell you in writing and let you know if and how you can appeal our decision.

How do I ask for access?

Enclosed is the Member Request to Access Protected Health Information (PHI) you requested. Please complete the entire form, sign it and return it to PHP. You may send your Member Request to Access to PHP at:

Providence Health Plan
Attn: Customer Service
PO Box 4327
Portland Oregon 97208-4327

You may fax your Member Request to Access form to 503-574-8731 or 800-425-0199 or you may hand deliver it (if mailing, use only the post office box address listed above) to the following address:

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

Please Note: The enclosed Member Request to Access must be completed, signed and dated.

If you have any questions or concerns, you may contact your Customer Service Team at 503-574-7500 or 1-800-878- 4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 503-574-8702 or 1- 888-244-6642. Customer Service representatives are available Monday through Friday, between 8 a.m. and 5 p.m.

Sincerely,

Providence Health Plan
Enclosure

Member Request to Access Protected Health Information (PHI)

Use this form to request a copy of your PHI in a Designated Record Set that Providence Health Plan (PHP) or one of its Business Associates maintains. If you need assistance completing the form, please contact the PHP Customer Service number listed on your member identification card. You must complete all the fields on this form.

PART A: MEMBER INFORMATION

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: DELIVERY OF THE REQUESTED INFORMATION

I request to review protected health information (PHI) about me in a designated record set held by Providence Health Plan (PHP). By placing, an "X" in the appropriate box below, please indicate who will receive your information. Send my PHI to: **(select only one)**

- ☐ Me at the address listed above (If email is selected below in PART C, PHP will not mail to the address above.)
- ☐ I request that PHP send my PHI, as specified in Part D, to the designated third party listed below.

Name	Address	
City and State	Zip Code	Phone Number

PART C: FORMAT/MANNER OF THE REQUESTED INFORMATION

By placing, an "X" in the appropriate box below, please indicate in which format/manner you wish to receive/review your information. Send my PHI: **(select only one)**

- ☐ Send paper copies of my records, identified below in Part D, via US certified mail.
- ☐ Send electronic copy of my records, identified below in Part D, via email. Note: Information will be sent to the email address provided below by secure (encrypted) email unless otherwise specified.

Email address: _____

If you prefer the e-mail be sent unencrypted, please initial here: _____

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

If you prefer the CD be sent unencrypted, please initial here: _____

(Warning: Some level of risk may be associated with sending your PHI via unencrypted emails or CDs as they could be accessed and read by unauthorized third parties.)

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

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

PART D: DETAILS OF PHI REQUEST

I request the protected health information (PHI) contained in the following records. Please place an "X" next to the items you are 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 information on claims received but not yet processed – if you would like the status of those claims you may call Customer Service at the toll free number listed on your PHP 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 specifically authorize the release of the following sensitive information, if such are part of my record, and will only be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure. *I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.

(Initial all that apply):

_____ AIDS or HIV

_____ Maternity/Pregnancy
(Reproductive Health)

_____ Alcohol/Drug/Substance Abuse
(Diagnosis, treatment or referral
information) *

_____ Mental Health Data and Records

_____ Genetic Information (services or
tests)

_____ 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: _____
(Member Signature)

Date: _____

- OR -

By: _____
(Member's Designated Legal Representative/Guardian Signature)

Date: _____

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 documentation if you are the legal guardian or Holder of Power of Attorney.**

- *Note: To parents/legal guardians of minors: state laws may prohibit Providence Health Plan from acting on your request about Sensitive Information without written authorization from the minor member. (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。

تظو حلم: اذا تنك ثدحت ركذا ةغلا، ناف تامدخ قدعاسملا قيوغلا رفاوتت كل ناجملا ب. لصتا مقرب 1-800-878-4445 (مقر فتاه مصلا مكبلو: (TTY: 711).

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

រឿងនេះ ៖ បើសិនជាអ្នក កនិយាយ ភាសាខ្មែរ, ៖ សេវាជំនួយ វិជ្ជាជីវៈ ភាសា គឺអាចមានសំរាប់ អ្នក។ ចូរទូរស័ព្ទ សេវាជំនួយ ៖ ០៧១១ 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).

1-800-878-4445 مت سا بیریڈ گ. ش ام بی ار گ ارینا ص ب ترو بزی ناستیتلا ه، کید ن می گنگف و فی سرا بز ناب هگا ر: جوت ه ف می ش ب د ب ا (TTY: 711)

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)

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