Providence Health Assurance | health share Health Share of Oregon

ProvidenceHealthAssurance.com/OHP

MEMBER ACCESS TO RECORDS FORM

Fill out this form to ask for a copy of your health information, like claims, enrollment, or prior authorization, from Providence Health Assurance (PHA). This request is only for insurance records that PHA has. If you need other medical records, get in touch with your doctor's office. Use your member ID card to help you fill in the details 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: INDICATE 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 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 can be reached Monday through Friday, between 8 a.m. and 5 p.m.		

❖ ❖ ❖ ❖ ❖

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

What does my right to access my health information mean?
You and someone you choose to help you can get a copy of your health information, which is called protected health information (PHI). Providence Health Assurance (PHA) keeps these records in a special group called a designated record set (DRS). This is done because of rules from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The DRS includes records that help PHA make decisions about you as a member, like enrollment, claims, and case management.

What should I know about using this right?
- You can ask for copies of your health information from PHA.
- PHA will answer you request in the time allowed by HIPAA or state law, which might need a faster reply. If we can't respond in time, we'll send you a letter to explain why. This request is only for records held by PHA. If you need records from your doctor, you'll need to ask them directly.
- You might not be able to get all types of records. For example, you can't get records used for legal or administrative things.
- Phone calls to Customer Service calls are recorded for training and quality, but PHA doesn't have to keep or share these recordings.
- Appeals and Grievances: You can ask for a copy of the papers PHA uses for appeals or grievances. Call Customer Service using the number on your PHA ID card.

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