# Request for Access to Inspect and/or Copy of Protected Health Information

**Can you explain what this right means?**

You have the right to request a copy of protected health information that Network Health has about you in a designated record set. A record set may include information related to enrollment, billing, claims or medical management.

Network Health is not always required by law to provide access to certain protected health information. For example, Network Health can deny access to psychotherapy notes and information compiled in anticipation of, or for use in, civil, criminal or administrative actions or proceedings.

**How do I make a request?**

Print and complete the following form. Don't forget to sign and date the form. Return the completed form to:
Network Health
Attn: Compliance Department
1570 Midway Place
Menasha, WI 54952

You will receive a written response indicating the approval or denial of your request.

**Request for Access to Inspect and/or Copy of Protected Health Information**

**Complete and mail this form to:**
Network Health, Attn: Compliance Department, 1570 Midway Place, Menasha, WI 54952

**Complete the following for the individual whose information is being requested:**

Name ______________________ Member/Participant No. ______________________

Street Address ______________________ Telephone No. (______)______________________

City/State ______________________ Last Four Digits of Social Security No. __________

ZIP Code______________________ Birth Date __________ / __________ / __________

I ______________________, hereby request a copy of the protected health information requested below. **Please indicate how you would like to receive the information:**

- ☐ Mailed to the address above
- ☐ Mailed to an alternate address (please provide): ______________________
- ☐ Will pick up in person at Network Health
- ☐ Other (please specify): ______________________

I request the protected health information contained in the following records. I will specify the details for you in the blanks below.

☐ **Enrollment Information (underwriting and application process)**

Provider(s)______________________

Detail of Issue______________________

☐ **Claims Information**

This is regarding ☐ a claim ☐ a service provided

Date(s) of Service______________________

Provider(s) ______________________

Detail of Issue______________________

☐ **Case or Medical Management Information**

Date(s) of Service______________________

Provider(s) ______________________

Specify Information Requested ______________________

Detail of Issue______________________

☐ **Billing/Premium Information**

Billing Period______________________

Detail of Issue______________________

☐ **Other**
Please describe ______________________________________________

Pursuant to federal law, I understand that Network Health may deny this request. By signing this form, I am confirming that it accurately reflects my wishes.

Signature of Requestor ______________________________ Date ____________

**If signed by a Personal Representative:**

Name of Personal Representative ____________________ Telephone No. ( _____ ) __________
Relationship to individual or nature of authority ________________________________
Signature of Personal Representative __________________________ Date __________

(If you are the personal representative, other than a parent or legal guardian, please attach a copy of any documents verifying your position as personal representative.)

**(Please submit a separate request for each individual.)**