Midwest Security
INSURANCE COMPANIES
A UnitedHealth Group Company

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Name:____ Enrollee #:________________________

As provided for by the Health Insurance Portability and Accountability Act (HIPAA), I am exercising my right to access my protected health information (PHI). I understand that information requested below will be provided to me in the form of a paper report and that I will not be charged for this service.

INFORMATION DATES

Please indicate the dates from which PHI is being requested:

Start Date:_________________ through End Date:_________________

TYPE OF INFORMATION REQUESTED

Please check the boxes below that apply to the type of PHI you are requesting access to:

- ☐ Enrollment records
- ☐ Premium/contribution payment records
- ☐ Underwriting records
- ☐ Claim payment records
- ☐ Case Management/Utilization Review records
- ☐ All of the above

____ _________________

Signature of Patient or Patient's Authorized Representative **Date**

____

If signature is Authorized Representative's, please indicate relationship or authority to act for individual.

GROUP HEALTH PLAN REVIEW/REPLY SECTION

This section is for use by authorized representatives of the group health plan only.

Date Received:______________

Title of Reviewer:______________________________________ Date:______________________

This request for access to PHI is being:

☐ Approved. Paper copies of the requested information will be mailed to you within 30 days. You will not be charged for this service.

☐ Declined, as allowed under the Health Insurance Portability and Accountability Act (HIPAA), because the information requested:

☐ Is psychotherapy notes.

- ☐ Has been compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding.
- ☐ Is subject to the Privacy Act, 5 U.S.C. §552a, and the denial meets the requirements of that law.
- ☐ Was received from a source, other than a health care provider, that requested confidentiality and the access would be reasonably likely to reveal that source.
- ☐ Has been determined by a licensed health care professional as likely to endanger the life or physical safety of the individual or another person.
- ☐ Has been determined by a licensed health care professional as likely to cause substantial harm to another person referenced in the information.
- ☐ Was requested by a personal representative and a license health care professional has determined that access is likely to cause substantial harm to the individual that is the subject of the information or another person.

If the denial of your request as marked above involved a decision by a licensed health care professional regarding the potential harm or to yourself or another person, you have a right to have that decision reviewed. If you wish to appeal the decision, please submit a written request to have the decision reviewed. The decision will be reviewed by a licensed health care professional that was not involved in the original decision and a response provided to you within 30 days of our receipt of your appeal.

If you believe your privacy rights have been violated, you may file a complaint with the plan or the Secretary of Health and Human Services. Complaints should be filed in writing and sent to the Legal Department of Midwest Security. The plan will not retaliate against you for filing a complaint.