

**NORTHWESTERN HEALTH SCIENCES UNIVERSITY HEALTH PLAN
REQUEST TO INSPECT OR COPY PROTECTED HEALTH INFORMATION**

Name: _____

Date: _____

I. Request to Inspect or Copy Protected Health Information

I hereby request to review protected health information (PHI) about me in a “designated record set” held by Northwestern Health Sciences University (NWSU) Health Plan in accordance with Health Insurance Portability Accountability Act of 1996, as amended (HIPAA).

A “*designated record set*” is a group of records maintained by or for NWSU including enrollment, payment, claims adjudication and health plan case or medical management record systems; or records used by or for NWSU to make decisions about individuals. The term “record” means any item, collection or grouping of information that includes PHI this is maintained, collected, or disseminated by or for NWSU Health Plans.

Check any of the below, as applicable:

I want to inspect PHI about myself maintained in the designated record set.

I want to obtain a copy of PHI about myself that is maintained in the designated record set.

I request that a copy of PHI about myself be mailed to the following address:

I request that the information be provided in the following format: (circle one)

E-mail Computer Disk Paper, mailed Paper, view in HR

I understand that if the format requested is not readily producible, NWSU will provide a readable hard copy form or such other form or format as agreed to by NWSU and by me.

I do/do not (circle one) agree that NWSU may provide a summary of the health information instead of allowing me to review the information.

If the same PHI that is the subject of a request for access is maintained in more than one designated record set or at more than one location, NWHSU will only produce the PHI once in response to a request.

II. Other Important Information

I understand that NWHSU has 30 days to respond to this request, and that if someone else holds the information or the information is off-site, the response time is 60 days. If NWHSU is unable to take action within the applicable time period, NWHSU may extend the time for such action by 30 days, provided that NWHSU, within the applicable time period, gives me a written statement of the reasons for the delay and the date by which NWHSU will complete its action on the request.

I understand that if NWHSU grants this request, in whole or in part, it will inform me of the acceptance of this request and provide the access requested. In that event, NWHSU will arrange with me for a convenient time to meet in Human Resources to inspect or copy the PHI, or it will provide me with a copy as I have requested. However, if NWHSU denies the request, in whole or in part, it will provide me with a written denial.

I agree to pay any fees for copying, summarizing, or explaining my health information. Fees will be reasonable and cost-based and will include only the cost of copying, postage (if mailed), and preparation of a summary (if requested).

I understand that this request does not apply to certain health information, including (1) information that is not held in the designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and (4) other health information not subject to the right to access information under HIPAA.

III. Signature of Individual or Individual's Representative

Signature of individual or individual's representative
(Form *MUST* be completed before signing)

Date

Printed name of the individual's personal representative:

Relationship to the individual, including authority for status of representative:
