

MEBS, INC.

**REQUEST FOR ACCESS TO
PROTECTED HEALTH INFORMATION**

I, _____ (name), _____ - _____ - _____ (Social Security number), hereby request a copy of my health information from MEBS/ _____ (Employer) Group Health Plan for the following dates: _____. I request the health information contained in MEBS' designated record set which is comprised of the following records (please check one or more):

- enrollment
- premium/contribution payment
- case or medical management
- customer service
- claims, billing and EOB information relating to the following service or claim:
(specify date of service and/or medical condition)

- all of the above
- other (please specify) _____

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 litigation; and (4) other information not subject to the right to access information under HIPAA.

I understand that I may access my health information through any of the following methods (please check the desired method):

- I prefer to inspect and/or copy the requested information in person and will arrange for a mutually convenient time to come to MEBS by calling MEBS' Claims Manager at (800) 968-6327. I understand I will be charged a per page copying fee.
- I prefer to have the requested information copied and mailed to me at the following address: _____ . I understand I will be charged a copying and postage fee.
- I prefer to receive a written summary of the requested information, instead of the complete records, for a fee.

Signature of Requestor Date

If signed by personal representative:
Name of personal representative: _____

Relationship to participant or nature of authority:

Signature of Personal Representative Date