Request to Inspect or Receive a Copy of Protected Health Information

Complete and mail this form to:

Privacy Officer
UNITE HERE HEALTH
P.O. Box 6020
Aurora, Illinois 60598-0020

Participant Name _____

Participant SS# _____

Patient Name _____ **Patient SS#** _____

Patient Date of Birth _____ **Relationship to Participant** _____
(month-day-year)

I am requesting (as described in the UNITE HERE HEALTH Notice of Privacy Practices) to inspect and/or get a copy of my Protected Health Information kept by, or for, UNITE HERE HEALTH.

Reports Furnished Free of Charge

UNITE HERE HEALTH will provide you with a report of your claim payment history free of charge. This individual payment report (RIP Report) allows you to see a summary of how your claim(s) was paid. You will see the same information that appeared on the Explanation of Benefits (EOB) you received when benefits for that claim(s) were processed.

Place a check mark (✓) in the box next to the item that best identifies your request:

❑ Please provide a summary of my claim payment history for the following treatment dates:

_____ to _____, showing all health care providers.

❑ Please provide my detailed claim payment history for the following treatment dates:

_____ to _____, showing all health care providers.

❑ Please provide a summary of my claim payment history for all claims.

❑ Please provide my detailed claim payment history for all claims.

Inspection or Requests for Which You Can Be Charged

If you want to come to the UNITE HERE HEALTH Office to inspect your protected health information, you must call the Privacy Officer at (630) 236-5100 to discuss the nature of the protected health information that you want to inspect and to arrange a time to do so.

If you want to review more protected health information provided in one of the reports described above, you must call the UNITE HERE HEALTH Privacy Officer at (630) 236-5100 to discuss the type of protected health information you want to review and the format you want to receive it in.

Requested Format:

We will try to provide the information to you in the format that you request. If we are unable to accommodate your request in a specific format, we will contact you to make other arrangements.

❑ Paper ❑ Electronic (if electronic, please specify the format): _____

Address to Send Records to:

First Name _____ Last Name _____

Street _____ Apt # _____

City _____ State _____ Zip _____

I agree to pay in advance any fees for copying or summarizing my health information. Fees will be reasonable and will only include the cost of copying, preparation of a summary (if I agree to a summary), and postage (if I request that a copy or summary be mailed).

Signature of Patient (parent or guardian if the patient is a minor) or Personal Representative _____ Date (month-day-year) _____

Printed Name _____ Phone Number Where We May Contact You ( )

Relationship to Patient _____

For UNITE HERE HEALTH Use Only

❑ Accepted ❑ Denied Date Received: _____

Privacy Officer Signature: _____ Date: _____

Dept. Manager Signature: _____ Date: _____

Date Response Mailed Back: _____