Request for Protected Health Information

ASPIRUS HEALTH PLAN

You have the right to request access to protected health information about you that is maintained by Aspirus Health Plan. Aspirus Health Plan will evaluate your request and will either grant your request or explain the reason why the request will not be granted no later than thirty (30) days from receipt of your request. Aspirus Health Plan may charge you a reasonable cost-based fee for your request. Your right to access does not extend to information complied in reasonable anticipation of litigation; psychotherapy notes; information not maintained by Aspirus Health Plan; or other information not subject to the right of access under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule.

NOTE: Aspirus Health Plan does not maintain original medical records. We advise members to contact their provider's office, clinic, or hospital to obtain medical records. Members must follow the provider's procedures for accessing medical records.

Return completed form to: Aspirus Health Plan, ATTN: Legal/Privacy, PO Box 1062, Minneapolis, MN 55440
or email to: CustomerService@aspirushealthplan.com. If you have questions, please call Customer Service at: 866.631.5404.

PART A: MEMBER INFORMATION

Member Last Name	Member First Name	MI	Member Date of Birth
Member Street Address	**City**	**State**	**Zip Code**
Phone Number *(include area code)*	**Cell Number** *(include area code)*	**Subscriber Number** *(ID Card)*	

PART B: SCOPE OF ACCESS REQUEST

In accordance with the HIPAA Privacy Rule, I request a copy of my protected health information (PHI) held by Aspirus Health Plan for the following dates:

_____

I request protected health information (PHI) contained in the following records: *(please check all that apply)*

☐ Designated Record Set* ☐ Enrollment ☐ Customer Service ☐ Premium/Contribution Payment ☐ Case or Medical Management
☐ Claims, Billing, and EOB Information relating to the following service or claim: *(specific date and/or medical claim)*:

_____

☐ Other: _____

*Designated record set has the same meaning as set forth in the HIPAA Privacy Rule, limited to enrollment, payment, claims adjudication, and case or medical management records systems maintained by Aspirus Health Plan or used, in whole or in part, by Aspirus Health Plan to make decisions about an individual.

NOTE: Information used in quality control efforts—not for coverage determinations—is NOT part of the designated record set because it is not used to make decisions about people.

PART C: FORM, FORMAT, AND MANNER OF ACCESS REQUEST

☐ **Inspection.** I would like to inspect the above information at Aspirus Health Plan during regular business hours (8 a.m. to 4:30 p.m.). If my request is granted, please:
- ☐ **Call me via telephone** *(at the number listed above)* OR
- ☐ **Mail me a letter** *(at the address listed above)* to let me know when I may come to Aspirus Health Plan to inspect the information.

☐ **Paper Copies.** I would like paper copies of the requested information:
- ☐ **Mailed to me** at mailing address listed above
- ☐ **Mailed to me** at a different mailing address *(please provide the information here):*

_____

☐ **Digital Copies.** I would like digital copies (CD/DVD) of the requested information:
- ☐ **Mailed to me** at mailing address listed above
- ☐ **Mailed to me** at a different mailing address *(please provide the information here):*

_____

☐ **Electronic Copies.** I would like electronic copies of the requested information emailed to me at the following email address:

_____

By requesting electronic copies and signing this form, I acknowledge that I am aware of and assume the risks associated with transmitting unencrypted email, including that it may be intercepted, forwarded, printed, and stored by others. I understand that Aspirus Health Plan is not responsible for unauthorized access of PHI while in transmission to me or the third party I direct and is not responsible for safeguarding my information once it is delivered to me or the third party I direct.

☐ **Summary.** I would prefer to receive a written summary of the requested information instead of the complete record.

I understand that I may be charged a fee for copying and for any supplies (including CD/DVD) used to create the copy and postage fees for transmitting the information I have requested.

PART D: MEMBER SIGNATURE OR AUTHORIZED REPRESENTATIVE/GUARDIAN

Member signature or Designated Legal Representative/Guardian signature	Date
X	

If authorized representative: (1) print your name, (2) state the legal authority for your status as Member's representative, and (3) attach supporting documentation:*

*If you are the member's legally authorized representative as defined by HIPAA or other applicable federal and state law, you must submit the applicable documentation or other proof of legally authorized representative status that establishes your authority including but not limited to: **Power of Attorney** – Valid power of attorney document, **Guardian** – Valid court order appointing you as guardian, or **Executor** – Valid court order appointing you as executor of a decedent's estate. Legally authorized representatives must provide notice of any change to their status or authority.

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. *We* do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:
Provide free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If *you* need these services, contact *us* at the phone number shown on the inside cover of this *contract*, *your* id card, or aspirushealthplan.com.

If *you* believe that *we* have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, *you* can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1.866.631.5404 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً . اتصل بن اعلى رقم الهاتف 1.866.631.5404(رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_: य_द आप ि हंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 致電 1.866.631.5404 (TTY:711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.866.631.5404 (TTY:711).